HIPAA Gap Analysis

Transaction and Code Sets
Strategy Deliverable

Prepared for HHSC/DHS
by NHIC
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Introduction

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) Administrative Simplification regulations became effective October 16, 2002. HIPAA provisions mandate standardization of certain communications among health plans, clearinghouses, and providers who submit health information electronically. It also mandates the use of common coding structures, as outlined in the final rule. The Health and Human Services Commission (HHSC) and the Texas Department of Human Services (DHS) have been granted an extension from the original implementation date to October 16, 2003.

The HIPAA assessment team reviewed the impact of the HIPAA Transaction and Code Sets regulation on the Acute Care and Long Term Care systems maintained by the National Heritage Insurance Company (NHIC). This assessment's scope included gap analysis, operational impacts, and recommendations for HIPAA compliance.

The assessment considered HIPAA Administrative Simplification provisions, including the following major requirements:

- Transaction format standards
- Code set standards
- Employer Identifier standards as they relate to transaction/code sets

The Executive Summary addresses, at a high level, the assessment approach, outcome and recommendations. Following the Executive Summary, additional sections address the Transaction Gap Analysis results, Code Set results, Third Party Interfaces, Provider Communications, and Glossary of HIPAA terms and acronyms used within this document. The Appendices referenced in the Table of Contents are included in this document as cover pages only, as they are saved as separate files on the CD-ROM. The Appendix files contain the supporting information upon which this report is based.

Executive Summary

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has established regulations for the exchange of health care-related data between providers, clearinghouses, and health plans. These regulations require the use of standard transactions in the exchange of health care data. It also specifies certain data content through the use of standard code sets and identifiers. The ability to comply with the regulations must be in place by October 16, 2002, unless the covered entity requests an extension until October 16, 2003.

National Heritage Insurance Company (NHIC) was contracted by the Health and Human Services Commission (HHSC) to perform a HIPAA Technical Assessment of the Acute Care and Long Term Care systems that comprise the Texas Medicaid Management Information System (TMMIS). Hereafter in this document the combined systems will be referred to as the TMMIS.

This strategy document contains the results of the NHIC assessment, and upon approval from HHSC, the Assessment will be complete.

Approach

The HIPAA Technical Assessment was performed in two phases: definition and the gap assessment. The definition phase outlined the scope and deliverables of the gap assessment. The work accomplished under the gap assessment phase was divided into four components:

- Mapping the current systems' data elements and processes to the appropriate HIPAA-mandated formats and required values
- Identifying the gaps or differences between the current system and the HIPAA requirements
- Assessing the impact of those gaps on the current system
- Resolving the gaps and designing an approach to achieve HIPAA compliance

The process of mapping the data elements and processes to the HIPAA-mandated formats and required values produced transaction and code set crosswalks. The LTC transaction set crosswalks were delivered to DHS. DHS produced the code set crosswalks for the LTC code sets. The Acute Care code set crosswalks were delivered to HHSC and is included in Appendix B. The Acute Care transaction set crosswalks were reviewed with HHSC during work group sessions. These crosswalks are on file at NHIC and because of their number and size, they were not included in this document. They are available on request.

During the assessment, NHIC identified the gaps or differences between the current system and the HIPAA requirements and produced an Issues list containing each

instance where a field did not map on a one-on-one basis. This list was used in analysis to determine which gaps could be resolved and which gaps required a state decision for remediation. The Issues List is included in this document in Appendix A.

The gaps were analyzed to determine the technical and operational impacts, as well as impacts to the providers and other external interfaces. These impacts were defined for Acute Care in Definition Documents and in Definition/Analysis Documents for LTC. NHIC created a sub-project for each related set of gaps. Alternative and recommended solutions for every sub-project were identified and documented. Acute Care sub-projects were documented in Analysis Documents which are included in Appendix C. The Acute Care Analysis Documents were approved by the HHSC HIPAA Review Board, with the exception of Adjustments and SUR, which are scheduled to be presented on December 2. LTC solutions were documented in Solutions Documents and are also included in Appendix C. HHSC and DHS approved the LTC Solutions Documents.

Findings

The TMMIS currently engages in business functions associated with the following standard HIPAA transactions: the 837 Health Care Claim (Dental, Institutional, and Professional), 835 Claims Payment and Advice, 278 Health Care Services Review, 276/277 Claims Status Request/Response, and the 270/271 Eligibility Benefit Request/Response. This means that the TMMIS needs to be prepared to accept the standard transactions with the applicable code sets whenever a covered entity submits this information electronically or, when an entity not defined as covered requests to use that standard format voluntarily. The TMMIS currently processes with nonstandard code sets for procedures, modifiers, EOBs, and Claim Status Inquiry. Additionally, some of the data elements within a given transaction use nonstandard values.

Currently, trading partners electronically submit state-defined formats that are equivalent to the 837, 835, 276/277, and 270/271 transactions in function, but not in format or content. TDHconnect, the software package offered by the TMMIS to providers for the electronic submission of transactions, also submits in state-defined formats. The enrollment (834) and premium payment (820) transactions, which are also addressed by the HIPAA mandate, are not business functions currently supported within the TMMIS.

While national codes sets are used, the TMMIS relies heavily on state defined codes (local codes) for medical services, claim status inquiry codes, and explanation of benefits. The TMMIS does not use the Employer Identification Number (EIN), therefore no changes are needed for this identifier.

Based on the findings from the gap assessment, the following table presents a summary of the HIPAA standard transactions and a rating to measure current HIPAA readiness.

The Rating scale is defined as:

1. No current use of any part of the HIPAA standard.
2. Use of some parts of the HIPAA standard is in place.
3. Many components of the HIPAA standard are being used.
4. The use of the standard is in place to meet the minimum HIPAA requirements without adding functionality to the existing the TMMIS.
5. Use of the HIPAA standards have been optimized (that is, exceeds minimum requirement by also using data elements in processing agreements in place voluntarily with entities not required to use the HIPAA standards)

Transaction	Description	Rating
837	Health Care Claim	1
835	Claim Payment and Advice	1
278	Health Care Service Review	1
276/277	Claims Status Request/Response	1
270/271	Eligibility Benefit Request/Response	1
Code Set	**Description**	**Rating**
Medical Code Sets	Diagnosis, procedure, revenue, modifier codes (Local codes)	2
Claim Adjustment Reason Code and Remark Codes	Remittance advice codes (EOB codes)	1
Claim Category Codes, Claim Status Codes	Claim status inquiry codes (EOPS codes)	1
Nonmedical Code Sets	Codes sets defined within the Implementation Guides	3

Recommendation

The magnitude and scope of changes mandated through HIPAA will have a significant impact on the TMMIS. Over the last seven months, NHIC personnel have analyzed the existing environment to determine the impact HIPAA will have on business processes, interfaces, and systems.

HIPAA's impact will fundamentally change the current and future operations of Texas Medicaid. It is far-reaching and will impact various departments within HHSC and DHS, as well as their business partners, vendors, and the provider community. The HIPAA legislation will change how HHSC/DHS develops and implements new programs; the way HHSC/DHS interacts with state legislation; how providers collect, submit, and receive information; and how the TMMIS integrates these changes.

Executive HHSC/DHS leadership support is critical. The implementation of HIPAA will require large, dedicated NHIC and HHSC/DHS teams. Because HIPAA impacts almost every department, representatives from each will need to be involved in decision-making, designing, testing, and implementing the new requirements. It is critical that all parties are educated on the requirements and how they impact the current environment. HHSC/DHS did file for an extension, moving the date of compliance to October 16, 2003. With less than one year remaining, HHSC/DHS and NHIC must focus their resources and energy on those tasks that will provide the greatest impact toward meeting HIPAA compliance. Teams should be formed now to begin remediation. As the changes are enterprise wide, a freeze on system changes would be ideal to help reduce the risk, time, and cost associated with having to consistently migrate the new changes into the HIPAA version of the code and then re-testing. At a minimum the state should participate in minimizing the number and scope of changes completed during this time.

While the details of the assessment are discussed in separate sections or attachments of this document, a list of the high impact gaps is provided below:

- HIPAA requires the use of national medical code sets, which does not include local procedure and modifier codes.
- Long Term Care providers submit fields such as Bill Code and Budget Number that may no longer be submitted. These fields are critical to how the Long Term Care system is designed.
- HIPAA supports up to 999 details per claim; 28 details is currently the limit within the TMMIS.
- The software supplied by HHSC/DHS to providers to electronically submit and receive transactions (TDHconnect) uses nonstandard formats. Providers must submit transactions in the HIPAA-compliant formats.
- HIPAA requires the use of standardized messages on the electronic Remittance Advice. Currently the TMMIS uses state-defined messages.
- HIPAA requires the use of standardized messages on the electronic Claims Status Response. Currently the TMMIS uses state-defined messages.
- Long Term Care providers use a state-defined X12 4010 professional format. Needed data elements will require providers to submit using dental, institutional, and professional compliant X12N 4010 formats.
- HIPAA requires payers to electronically accept and process prior authorization requests. Currently, this business function is supported through non-electronic means.
- Much of the data returned on the existing claim status inquiry, are no longer supported by HIPAA formats. The Claim Status Inquiry (CSI) application will need major revisions to be made HIPAA-compliant.

- Much of the data returned on the existing eligibility verification applications is not supported by HIPAA formats. The eligibility verification systems will require a redesign to achieve HIPAA compliance.
- HIPAA requires that the remittance payment and advice balance at the transaction, provider, and claim level. Currently no balancing is performed.
- HIPAA requires one check/warrant per remittance advice. The current Long Term Care system does not have this requirement.

Details associated with these items are included in the following sections, consisting of a separate section for each: Transactions; Code Sets; Interfaces; Provider Communications. For each of these items and other areas impacted by HIPAA, alternatives and recommendations were provided to HHSC in the form of Analysis documents that are attached as Appendix C. The final recommendations for the subprojects with major impact, as approved by HHSC/DHS in the HHSC HIPAA Review Board, are summarized in these sections. Most subprojects have been reviewed by HHSC/DHS, however those that were considered technical in nature or did not impact processes, such as mapping changes to be made by the clearinghouse, were not reviewed by HHSC/DHS, as agreed with the HHSC HIPAA PMO Director.

The final approval of this document by HHSC will complete the HIPAA assessment, and the next step is to begin remediation. NHIC staff will be available for any questions or discussions necessary to develop the understanding necessary for HHSC/DHS to make the decision to begin the remediation process.

HHSC has asked NHIC (CARTS 09262002I003) to remediate the TMMIS systems to achieve HIPAA compliance. The remediation project will consist of Business and Technical Design, Construction, Testing, and Implementation phases. NHIC has committed, in our response to the above CARTS, to provide HHSC/DHS with an estimate for business and technical design within ten business days of delivery of this document. Our estimates will be based on the recommendations made within this document. Upon completion of the Design phase, NHIC will provide complete estimates for Construction, Testing, and Implementation.

Transactions

Overview

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) required the Secretary of Health and Human Services to adopt standards for the electronic exchange of administrative and financial health care transactions. In practice today, most health care providers and health plans that conduct business electronically use many different formats for electronic transactions. With a national standard for electronic claims and other transactions, health care providers will be able to submit the same transaction to any health plan in the United States and that health plan must accept it. Health plans will be able to send standard electronic transactions, such as a remittance advice and referral authorizations, to health care providers. These national standards will make electronic data interchange a viable and preferable alternative to paper processing and ultimately simplify the exchange of health care information.

All covered entities must use the standards when conducting any of the defined transactions covered under HIPAA. Covered entities, which include all private sector health plans and government health plans, all health care clearinghouses, and all health care providers that choose to submit or receive these transactions electronically, are required to use these standards. A health care clearinghouse may accept non-standard transactions for the sole purpose of translating them into standard transactions for sending partners and may accept standard transactions and translate them into non-standard transactions for receiving partners.

Even if a health plan does not exchange information electronically, if it performs that business function, it must be able to support the electronic standard for that transaction. Health plans can do this internal to their systems or go through a clearinghouse.

Standard

As required by HIPAA, the Secretary of Health and Human Services is adopting standards for the following administrative and financial health care transactions:

- Health claims and equivalent encounter information (837 transaction)
- Enrollment and disenrollment in a health plan (834 transaction)
- Request and response about eligibility (270/271 transactions)
- Health care payment and remittance advice (835 transaction)
- Health plan premium payments (820 transaction)
- Request and response for claim status (276/277 transactions)
- Referral certification and authorization (278 transaction)
- Coordination of benefits (837 transaction)
- Standards for the first report of injury and claims attachments (also required by HIPAA) will be adopted at a later date

All the transactions adopted by this rule are from private sector standards organizations accredited by the American National Standards Institute (ANSI). All are from the Accredited Standards Committee (ASC) X12N, except the standards for retail pharmacy transactions, which are from the National Council for Prescription Drug Programs (NCPDP). Government agencies such as Medicare and Medicaid are actively involved in these organizations.

ANSI ASC X12N standards, Version 4010, were chosen for all the transactions, except retail pharmacy. The choice for the retail pharmacy transactions was the standard maintained by the NCPDP because it is already in widespread use.

Compliance with the final rule is required by October 16, 2002; HHSC/DHS applied for and was granted the offered extension to October 16, 2003. CMS suggested that entities begin using these standards earlier than the compliance date.

Approach

Three distinct stages were identified in the methodology to complete the HIPAA Requirements Assessment:

- Develop the Definition Document
- Assess the impact of the transaction rule to the TMMIS maintained by NHIC
- Develop a strategy for these systems to achieve compliance

The Definition Document further outlined the work to be performed during the HIPAA Requirements Assessment, the timeframe and resources needed to perform the assessment, and what outputs would be provided during the assessment. The Definition Document was delivered to HHSC on August 16, 2002 (NCARTS N08162002EXE002) and approved by HHSC on August 23, 2002 via response to the NCARTS.

The assessment mapped the existing transaction formats to the standard formats, identified areas of non-compliance or gaps, analyzed the impact of those gaps, and developed alternatives and a recommended solution to resolve the gaps. HHSC/DHS participated during each step of the assessment. The crosswalks mapping document and identified gaps were reviewed by HHSC/DHS during joint work sessions. The transaction crosswalks are on file at NHIC and are expected to continue to change throughout remediation. The crosswalks were not included in this document because of their number and size; however they are available upon request.

Following the crosswalk activities, workgroups or meetings were held with HHSC/DHS to review the analysis findings and to jointly determine the best approach to resolve each of the gaps. Approach, Definition, and Analysis/Solutions documents were created to document the impact of the gaps, potential alternatives, and recommended solutions. Internal reviews within NHIC were held to validate the analysis and recommended approach, as well as to ensure that technical, business, and operational aspects of the impact were considered.

Upon completion of NHIC's internal review, the documents were forwarded to HHSC/DHS. The Acute Care Approach, Definition, and Analysis documents were reviewed by HHSC selected state staff and approved by the HHSC HIPAA Review Board, chaired by the HHSC HIPAA PMO Director. Approvals of the documents by the Board were documented in the Review Board minutes, noting all participating attendees. The documents were then signed by the HHSC HIPAA PMO Director and returned to NHIC for imaging to the Central21 web site.

LTC Definition/Analysis and Solutions documents followed a similar approach. The documents were created by NHIC, approved internally through a review process, and then forwarded to HHSC/DHS. HHSC/DHS then approved the documents and returned the signed copies to NHIC for imaging to the Central21 web site.

Findings

HHSC/DHS currently performs the business functions that require a HIPAA standard 837, 835, 278, 276/277, and 270/271 format. Even though the exchange of information may not currently occur in an electronic format, HHSC/DHS needs to be prepared to accept a standard HIPAA transaction from their trading partners.

General Findings

By looking at the information used today by the Texas Medicaid program and identifying changes that must occur as a result of HIPAA requirements, the gap analysis identified the following conditions:

- Issues requiring an HHSC/DHS decision
- Data not used by the TMMIS today, but mandated by HIPAA
- Code sets used internally by the TMMIS that must be modified or developed as a result of HIPAA internal code sets
- Data currently used by the TMMIS today, but modified by HIPAA, such as length or type of data fields
- Data currently used by the TMMIS today, but HIPAA allows more or fewer occurrences of the data
- Data currently used by the TMMIS today, but not allowed by HIPAA

Refer to *Appendix A – Issues List* for more details regarding the gaps associated with data elements for the various transactions.

In the following pages each of the transactions are reviewed. The section for each transaction begins with a statement of the purpose of the transaction as defined by HIPAA. The way that the state currently uses the transaction is described in a current environment section. After that the Acute Care and Long Term Care gap analyses are summarized. The discussion of each gap contains a statement of the problem, the recommended solution, the impact and the level of risk associated with that gap. A

summary of the risks from all the subprojects analyzed is located in the Risk Section of this report. The complete analysis documentation for the various HIPAA analysis subprojects can be found in *Appendix C*.

837 Health Care Claim

This section provides an overview of the 837 standard for institutional, dental, and professional claims. The business impact is addressed and recommendations are provided for remediation.

Purpose of the 837 Transactions

The purpose of the 837 batch standard is to expedite an electronic data interchange environment for encounter/claims processing, adjustments, and reversals. To facilitate the standardization of data requirements and contents implementation guides were developed for each transaction. In the case of the 837 transaction, separate implementation guides were developed for the Dental, Institutional and Professional transactions. These guides provide a definitive statement of what data translators must be able to handle, and provide guidance to what a provider can place in the 837 transaction. The 837 implementation guides support the following functions:

- Claims
- Encounters
- Coordination of Benefits (COB) – Provider-to-Payer-to-Payer
- COB – Provider-to-Payer-to-Provider

While the implementation guides are used to define compliance to the standard, companion guides are documents that may be developed to provide the specific information or clarification needed to process or adjudicate the transaction within the trading partner's system. These companion guides cannot modify the definition, condition, or use of a data element or segment, add any additional data elements or segments, utilize any code or data values which are not valid, or change the meaning or intent of the implementation guides.

The 837D standard affects dental claims. The 837I standard affects inpatient, outpatient, Part A crossovers, and home health claims. The 837P standard affects professional, Part B crossovers, vision, and THSteps (EPSDT) claims.

Current Environment

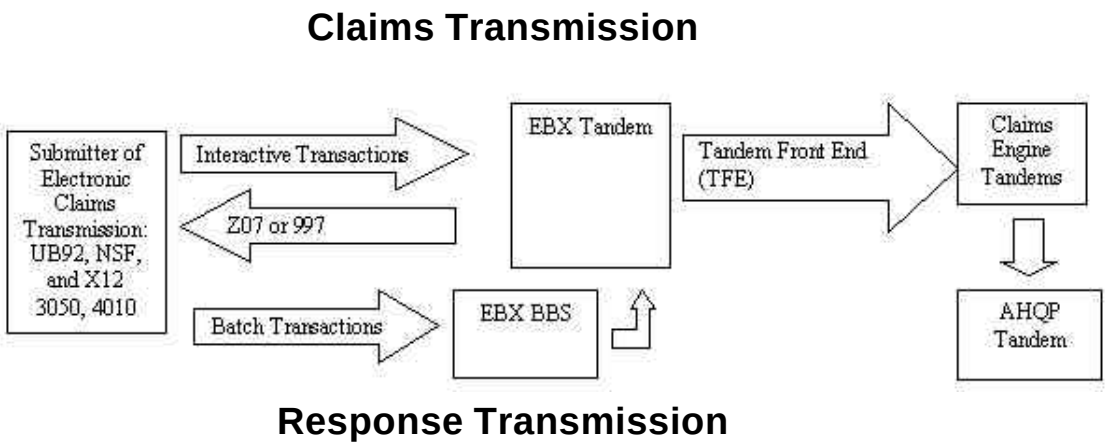
Electronic file formats for all claim types are sent in various non-standard formats. The clearinghouse maps the data to the Tandem Front End (TFE), the Acute Care claims processing, internal format.

Data is loaded to the system using the header and detail claim information. The TMMIS currently allows a maximum of 28 claim details on all claims.

Medicare Part A and B claims are sent from Medicare Intermediaries in proprietary UB92 or NSF formats. The files are then converted to state-defined formats before being loaded into the TMMIS.

Currently, the TMMIS processes claim adjustments submitted on paper, electronically, or system-generated. A claim adjustment is applied to change the outcome of a previously adjudicated claim.

The figure below shows the current flow of electronic claims submissions to the TMMIS and the corresponding acceptance rejection response returned to the submitter.



Acute Care Gap Analysis Results

This section provides an overview of the major gaps identified during the Acute Care 837 analysis, the recommended solutions for those gaps, the impact of the solutions, and the unique risks associated with the gaps and their solutions.

Number of Claim Details

HIPAA requires the acceptance of up to 50 details on professional claims and up to 999 details on institutional claims. The Acute Care system currently accepts a maximum of 28 details on all claims.

The recommended solution identified for this gap is to increase the claim adjudication and reporting systems to process up to the maximum of 50 details for professional and dental claims and 999 details for institutional claims.

This means that the file passed from the clearinghouse to the front-end edit server must accommodate up to 999 details, and every downstream server that touches claims must be able to handle 999 details. The claims engine servers will be changed to process up to 999 details on a claim. The *Vision21* databases and servers will be changed to handle 999 details. The claims interface file formats to various trading partners will be changed to allow the receipt of up to 999 details per claim.

A technical effort requiring many resources will be undertaken for what is expected to be a small number of very large claims. The biggest risk areas have to do with the ability of servers to store a large claim in memory, inability to show a claim in its entirety on a workstation and risk that downstream file users will not have prepared their systems to accept these large claims. Other areas of risk include the appearance of claim detail reports that may be adversely affected with one claim requiring several pages. The system must be comprehensively tested to ensure that a large claim received on a vendor file can be processed and reported properly throughout the system. The impact if these risks materialize is high.

More detail about this issue can be found in Appendix C, project CA0456-SP01, HIPAA 50/999 Details.

Increase in Size of Claim Fields

The HIPAA 837 formats have changed the size of the following fields used by the claims processing system:

- Billed Amount and other Amount Fields
- Medical Record Number
- Patient Account Number
- Covered Days
- Non Covered Days
- Billed Quantity
- Anesthesia Minutes

The recommended solution for all of the fields, except the amount fields, is to expand the size of the fields in the Acute Care system. The amount fields currently satisfy the minimum requirements of the standard and are believed to be already large enough to handle the largest reasonable claim billed amount, so the solution for these fields is to reject any claim with too large a total billed amount.

Each server in the claims processing and Vision21 systems that includes claim data may have to be changed to recognize the larger data input fields. In addition the format of any report that displays the field will have to be redesigned to accommodate the expanded fields. Similarly, the layout of any claim interface file that receives the fields will have to be expanded.

The primary risk with this issue is the billed amount field. If a claim is received on paper with a legitimate billed amount greater than or equal to ten million dollars, a manual contingency plan will be implemented to adjudicate the claim. The impact if this risk materializes is moderate. The state established a business policy to not allow claims with billed amounts greater than $9,999,999.99.

More detail about this issue can be found in Appendix C, project CA0456-SP18, Claim Header and Detail Field Changes.

Adjustments

Currently, an Acute Care electronic provider submits the original internal control number (ICN), provider number, and client number to adjust a claim. Additionally, only the data that the provider is requesting to be changed is submitted. More than 40 common gaps have been identified between the professional, dental, and institutional adjustments. These gaps include numerous data elements missing from the TFE that are required for receiving and processing adjustments under HIPAA. They also include several Acute Care fields that are not allowable by HIPAA but are currently used for processing by the Tandem Front End, adjustments server, or TDHconnect software.

The recommended approach is for the adjustment to create a complete replacement of the original claim. Fields used for claims processing will be mapped to the TFE. The provider will be required to submit the ICN and all the details from the original claim with changes as needed.

The solution impacts the system processes at the clearinghouse and the adjustment server, operational areas, and providers.

There is a risk that the electronic adjustment volume will increase based on HIPAA changes, and because adjustments suspend at a much higher rate than new day claims, suspense may increase. The impact if this risk materializes is moderate.

More detail about this issue can be found in Appendix C, project CA0456-SP21, Adjustments.

TPR/TARS Changes

NHIC collects and maintains Third Party Resource (TPR) information on clients to ensure Medicaid is the payer of last resort and to enable the Texas Automated Recovery System (TARS) to recover monies paid. NHIC requires TPR information from providers to ensure proper claims processing. The HIPAA-compliant 837 Professional and Dental formats do not support the collection of the TPR Insurance Company's address information and phone number. By federal law, Medicaid is the payer of last resort and is required to perform cost avoidance (denying the claim back to the provider if a primary payer is identified) and post payment recovery (billing the primary payer to seek recovery of its payment under subrogation and assignment of rights). The State must take reasonable measures to identify third party payers,

collect sufficient information to pursue claims against these payers, and seek reimbursement for paid assistance.

Several solutions are under consideration to include the required TPR information within the 837 formats. The final decision on where to map the missing TPR fields will be made in business design. The data needed in order to pursue reimbursement is not supported within any of the defined loops, segments, or data elements of the 837 professional or dental transactions. HHSC has determined the federal regulation to conduct post payment recovery by the collection of information needed to seek reimbursement of paid services (42 CFR 433.139) supercedes the HIPAA regulation.

Since the TMMIS required data would be received, the primary impact will be to the clearinghouse and to provider systems such as TDHconnect.

There is some risk that additional vendor and provider training will be required and additional customer service calls will occur. The impact if this risk materializes is moderate.

More detail about this issue can be found in Appendix C, project CA0456-SP11, TPR and TARS.

THSteps Exception to Periodicity Indicator

The HIPAA-compliant 837 claim input formats do not allow the input of the exception to periodicity indicator in THSteps medical and dental claims.

The provider will be asked to use modifiers on the procedure details to submit exception to periodicity information.

During business design, a decision will be made on whether the edits mapping server will automatically fill in the exception to periodicity indicator based on the information in the claim detail modifiers. If the exception to periodicity indicator continues to be used, then there will be no further impact. An alternative is for each server that uses the indicator to evaluate the modifier to determine if the exception is warranted. The indicator is used by the edit and audit servers, carried in the ad hoc datamart, and is passed to various interface files.

The probability of a significant risk materializing is low, as no risks have been identified at this time.

More detail about this issue can be found in Appendix C, project CA0456-SP05, Exception to Periodicity Indicator.

Ambulance

The HIPAA 837 claim input format does not have separate fields to collect origin, destination, and vital signs data for examiners to use in adjudicating ambulance claims.

The origin and destination information can be captured through the use of modifiers in the claim detail information. Instruction should be provided to ambulance providers to include necessary information about the patient's vital signs in the comment field.

The impact of this change is to the Operations and Training areas as well as to providers.

The probability of a significant risk materializing is low, as no risks have been identified at this time.

More detail about this issue can be found in Appendix C, project CA0456-SP08, Ambulance.

TMMIS Gap Analysis Results

Front-End Edit Responses

There are no reporting mechanisms required by the Transaction and Code Sets Final Rule for Front-End edits. However, three levels of reporting have been identified; transaction format syntax checking, HIPAA implementation guide compliance checking, and application system edits. For purposes of this report Front-end edits refers to the third level of reporting, the application system edits.

The approach for HIPAA will be to continue to return Front-End edit responses in a state-defined X12 format for any 837 transaction for the TMMIS. State-defined EOB codes will be used on the Front-End edit response.

This solution impacts the clearinghouse and the front-end edit server. Provider software that currently receives the response in a format other than X12N will be affected.

There is some risk because of the impact to Providers. The impact if this risk materializes is moderate.

More detail about this issue can be found in Appendix C, project CA0456-SP26, Rejected Claim Responses.

Mapping of Data Elements to State-Defined Formats

The required data to perform claims processing will be submitted in the fields required by the HIPAA 837 claim formats and with the internal code values that are required by HIPAA. The needed data on the incoming 837 must be mapped to the appropriate TFE fields.

A clearinghouse will continue to be employed to map the data from the HIPAA-compliant 837 formats to a TFE format. The clearinghouse or the edit server will perform internal code mappings.

The mapping of data elements to the TFE formats will require the clearinghouse to rewrite the existing maps. The impact if this risk materializes is moderate because the data that is delivered to the TMMIS processing system remains the same.

More details about the mapping of data elements to state-defined formats can be found in Appendix A.

New fields not presently Used by the TMMIS

The 837 format allows for additional information to be submitted that is currently not used by the TMMIS.

There are two recommended solutions to this issue depending on whether the information in the field would potentially assist in claims adjudication. Data elements that would not apply to Medicaid processing will not be mapped to the TFE. Data elements that have an identified future use will be mapped to the TFE and included on the claims image, but not mapped to the claims engine or Vision21 databases.

The impacted system areas include the clearinghouse, edits mapping, and claims imaging.

The probability of a significant risk materializing is low, as the fields are not used by the claims processing system.

More detail about data being required by the 837 claim formats that the TMMIS does not use in claims processing can be found in Appendix A.

Long Term Care Gap Analysis Results

This section provides an overview of the major gaps identified during the Long Term Care (LTC) 837 analysis, the recommended solutions for those gaps, the impact of the solutions, and the unique risks associated with the gaps and their solutions.

Number of Claim Details

HIPAA allows for a provider to submit up to 999 details on an institutional claim and up to 50 details on a professional or dental claim. Currently the LTC system allows for 28 details to be submitted on any one claim.

The state recommended solution is to limit the number of details to 50. The clearinghouse would accept up to 999 details for institutional and 50 for professional and dental. These claims would be sent to the LTC system for processing. However, a Front-End edit would return any claims that exceed the maximum number of 50 details. Increasing the number of details will impact the following areas:

- Process Claim Interface
- Front-End Edits
- LTC Policy
- CSI

- *R&S*
- Provider Support Windows (PSWin)
- *Vision21*
- Reports
- State systems that receive processed claim information

The LTC system has received just over 200 claims that have 28 line items (the current maximum). A risk is assumed with this solution since the LTC system will not be processing claims with the compliant number of line items for institutional claims. The system processing time could be impacted by the increase in line items per claim. Reports may become more cumbersome to read now that one claim can span more than one page. There may be a downstream impact to state processes that accept the processed claim information. The impact if this risk materializes is high.

More detail about the LTC system accepting fewer than 999 details can be found in Appendix C, project CA0456-LTC12, Maximum Number of Details.

Loss of Service Group

The HIPAA claim formats have no place for the Service Group field currently used throughout the LTC system.

The recommended solution is to have the LTC system derive the Service Group based on the Billing Provider and, in some cases, the use of modifiers. The solution creates a business requirement for dates on the Provider Service Group record.

The solution requires significant modification to the LTC system. The system will now determine the provider's association with a particular Service Group, a task it does not currently perform. The following areas will be impacted by this change:

- A new pre-claims processing program
- Front-End Edits
- Interface Edits
- State System

There is an increased risk of claim rejection/denial when the Service Group cannot be derived from the available information. There is also a risk that the derived Service Group is different than what the provider intended. DHS must ensure that valid Service Group information is on file for every provider. The impact if this risk materializes is high.

More detail about HIPAA claim formats not having a place for the Service Group can be found in Appendix C, project CA0456-LTC3, Service Group.

Loss of Budget Number

The HIPAA claim formats do not allow for a provider to submit a Budget Number. Currently, certain Service Group/Service Codes in combination with a client's

eligibility require a Budget Number to be submitted on a detail. The Budget Number determines from which source the detail will be paid. The Budget Number may be different for each detail on a claim. A claim may also contain some details with Budget Numbers and others without.

The recommended solution is for the LTC system to assume a Budget Number of '1' unless a modifier is sent. The modifier would indicate a Budget Number of '2.' In the future, these will be the only valid Budget Numbers.

The solution will require modifications in the following areas:

- Interface Edits
- Front-End Edits
- Pricing
- State Systems

The solution limits functionality and flexibility with regards to the processing of budgets. The state has determined that in the future only budget numbers '1' and '2 ' will be needed.

The probability of a significant risk materializing is low with the assumption the state will change data related to Budget Numbers other than '1' or '2' before implementation.

More detail about the loss of budget number can be found in Appendix C, project CA0456-LTC4, Budget Number.

Field Size Changes

HIPAA changes the length of many fields used within the LTC system.

The recommended solutions differ depending on the field in question. LTC is recommending an increase to only two fields (Client Control Number and Medical Record Number) because the state has indicated that there is no business need to increase the size of the other fields, and they currently meet the minimum standard requirements. The LTC internal claim format will change to accommodate the Client Control Number and the Medical Record Number. For the other fields that are not being increased, the full field submitted will be captured and stored on a claim image table in the system. NHIC and state staff will be able to view this information and the data will be available for return to the provider as needed.

The solution will require modifications to the following areas:

- Claim Response Files
- Creation of Claim Image Table
- Claim Loggers
- Front End Edits
- Purge Programs

- PSWin
- Interfaces
- Pricing

The probability of a significant risk materializing is low, as system changes are minimal.

More details about file size changes can be found in Appendix C, project CA0456-LTC21, Size Issues.

Adjustments

The HIPAA claim formats do not support certain information currently used in the LTC adjustment claim processing. Header Adjustments are currently submitted without details; however, this is not allowed by HIPAA. Detail Adjustments are submitted with an Adjusted Detail Reference Number; however, there is no place on the HIPAA claim format for this data. Additionally, the LTC system uses the Billed Unit Rate to assist in the determination of the original detail. Under HIPAA, this field will only be available on the 837I format.

The recommended solution is to discontinue the use of Header Adjustments and the Adjusted Detail Reference Number in the LTC system. The Billed Unit Rate will no longer be used, as part of the matching criteria to determine the original detail, instead the LTC system will be modified to use the Detail Total Billed Amount.

The solution will require modifications in the following areas:

- Front End Edits
- Adjustment Server

The probability of a significant risk materializing is low. Without the Adjusted Detail Reference Number, there is no relationship between the negative detail and the new positive detail. This is minor, as there is no rule that requires the provider to submit the negative and new positive on the same claim. Currently, these details could be billed on separate claims, in which case, no association is made between the negative and positive details.

More detail about claim adjustments can be found in Appendix C, projects CA0456-LTC8, Adjusted Detail Reference Number and LTC2, HAD Claims.

Loss of Billed Unit Rate for Variable Rates

The HIPAA 837P and 837D formats do not allow for a unit rate to be billed on a claim. Currently, submitters are required to include the Billed Unit Rate for each detail submitted. TDHconnect uses this rate to determine the Detail Total Billed Amount for each detail. This rate assists the providers to more accurately determine the amount they will be paid.

The Billed Unit Rate is also used to determine the paid rate in cases of variable rates. With variable rates, the LTC system determines the paid rate based on the lower of either the Billed Unit Rate or System Rate.

The recommended solution is for the LTC system to derive the Billed Unit Rate. The LTC system will divide the Detail Total Billed Amount by the number of Billed Units to derive the Billed Unit Rate.

The solution requires modifications in the following areas:

- Front-End Edits
- LTC Policy
- Pricing

Very few providers are paid by variable rates and LTC would never pay more than the system rate. There is some risk because, the derivation process will be dependent upon the provider calculating the Total Billed Amount correctly for each claim detail. The impact if this risk materializes is moderate.

More detail about HIPAA 837P and 837D formats not allowing for a unit rate to be billed on a claim can be found in Appendix C, project CA0456-LTC10, Billed Unit Rate.

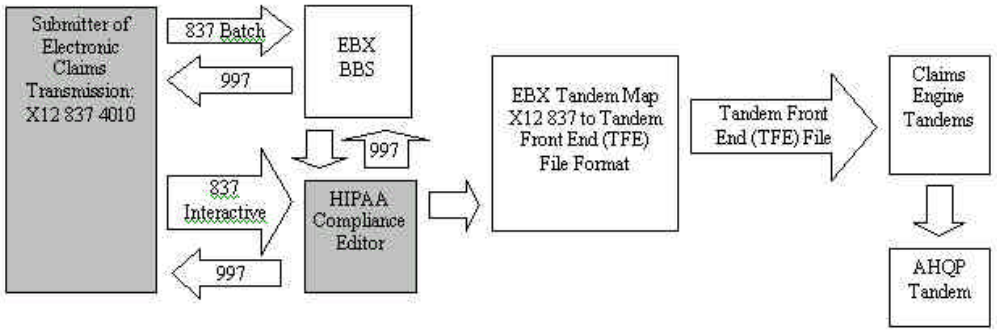
Summary

A clearinghouse will receive the 837 transactions, perform selected compliance edits, and map the data to a state-defined format. The clearinghouse may also split a claim file into separate files for new day claims and adjustments. In either case, the TMMIS system will perform front-end editing to determine if the claim will be accepted into the system for further processing. All Long Term Care claims and accepted Acute Care claims will be imaged and written to a database. Any submitted data that is not needed in processing, but does need to be returned to the submitter, will be captured so that it will be available when a return transaction such as an 835 is prepared. All the claim processing programs and subsequent reporting programs that process claims will be changed to accommodate the fields with size changes and the increase in the number of details.

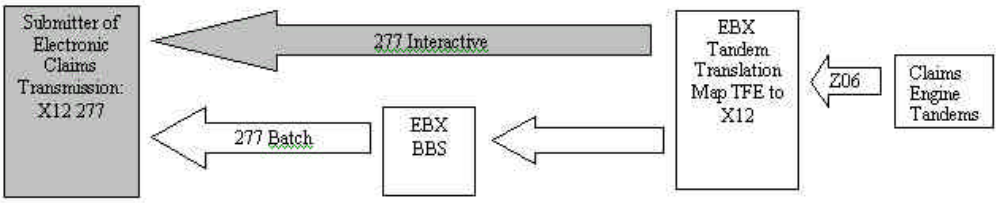
The assessment of the 837 transaction identified in excess of 1,000 data element changes that will impact multiple files, screens, reports and processes. Acute Care and Long Term Care claim formats must be compliant with the dental, professional, and institutional standards as required under HIPAA. Providers, HHSC/DHS, and NHIC staff will require training regarding the new, removed, and changed elements as well as format changes and code set changes.

The figure below depicts the proposed flow of electronic claims to the TMMIS, the acknowledgement returned by the clearinghouse and the corresponding acceptance rejection response from the TMMIS to be returned to the submitter. Areas that require changes are shaded.

837 Claim Transmission



Unsolicited 277 Claim Response Transmission



835 Health Care Claim Remittance Advice

This section provides an overview of the 835 Health Care Claim Remittance Advice standard. Business impacts are addressed and recommendations for remediation are provided.

Purpose of the 835 Transaction

The 835 is an outgoing transaction that can be used to make a payment, send a remittance advice, or make a payment and send a remittance advice. When generating an 835 transaction options include:

- Electronic Remittance Advice (ERA) with payment by check
- ERA and Electronic Funds Transfer (EFT) through a Depository Financial Institution (DFI)
- ERA with payment by separate EFT
- ERA and payment delivered separately, but processed by a Value-Added Bank (VAB)
- ERA with debit EFT

The 835 reports general payment information such as payee, payer, and payment method. It also includes claim adjustment reason codes related to adjudicated claims and services, as well as non-claim-specific transactions that affect the payment amount.

The 835 must balance at three different levels: the service line (detail level of claim), the claim (header level of claim), and the transaction (provider level).

Service Line Balancing. The submitted service charge minus the sum of all monetary adjustments must equal the amount paid for the service line.

Claim Balancing. The submitted charges for the claim minus the sum of all monetary adjustments must equal the claim paid amount. It is important to note that if service payment information is included, adjustments are reported in either the service level or the claim level, but not both. This will prevent counting the same monetary adjustment twice.

Transaction/Provider Balancing. The sum of all claim payments minus the sum of all provider level adjustments equals the total payment amount.

The 835 should only be used to transmit adjudicated claim information. Suspended claim information is not reported on the 835 transaction.

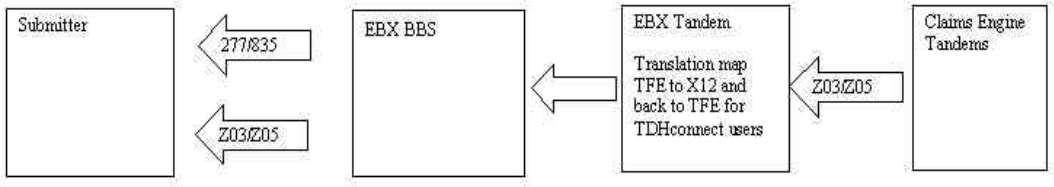
It is mandatory under HIPAA that the TMMIS be able to generate this transaction to report on claim/financial activity by all providers and/or third parties.

Current Environment

Currently, when the Electronic Remittance and Status (ER&S) is prepared and sent to the clearinghouse, a second file is also created that conveys information on pending claims for that provider. Both the ER&S and paper R&S contain the same local Explanation of Benefits (EOB) codes at both the claim header and detail levels to explain adjustment to payments as well as to convey remarks. However, monetary amounts and quantities associated with these payment adjustments are not reported. The current system does not balance the ER&S at the levels required by HIPAA.

Shown below is the flow of the ER&S and pending claim data from the TMMIS to the submitter.

ER&S Transmission



Acute Care Gap Analysis Results

This section provides an overview of the major gaps identified during the Acute Care 835 analysis, the recommended solutions for those gaps, the systems impacted by the solutions, and the unique risks associated with the gaps and its solutions.

Mapping of Data Elements to State-Defined Formats

Several data elements in the TFE do not map directly to the 835. The recommended solution is to change the TFE to include the data elements needed so that the clearinghouse can prepare a compliant 835.

A clearinghouse will continue to be employed to map the data from the TFE format output by the Acute Care system to the HIPAA-compliant 835 formats to be sent to the provider. In some cases the clearinghouse will also perform internal code mapping from previously used values. The cash financial ER&S server will perform the remaining internal code set mapping requirements as it prepares its output.

The recommended solution to map the data elements from the TFE format to the 835 will require the clearinghouse to rewrite the existing maps.

The probability of a significant risk materializing is low because the changes to the data delivered by the Acute Care system are minimal.

More detail about the 835 transaction gaps can be found in Appendix C, project CA0456-SP13, Electronic R&S Redesign and Balancing.

Balancing

The HIPAA 835 transaction requires claims to balance at the claim detail, claim header, and provider levels. The current Acute Care system does not balance at the levels required by HIPAA.

The recommended solution requires all processes which affect changes in the claim payment amount from the submitted charge be reported.

The claims processing server must capture, and make available to the ER&S process, the reason and the amount of each claim payment reduction and/or increase. In addition, any non-claim provider level reduction must be captured and reported on the ER&S.

There is some risk due to the system changes that will be made to capture and report each reason for a payment adjustment. The impact if this risk materializes is moderate.

More detail about this issue can be found in Appendix C, project CA0456-SP13, Electronic R&S Redesign and Balancing.

Procedure Code Changes During Processing

If the original and adjudicated procedure codes are different, both must be reported on the 835. The current Acute Care system does not retain the submitted procedure code if changed during processing.

The recommended solution is to create a new table that is used to maintain the originally submitted procedure codes. The new table information will be used to populate the applicable fields on the 835.

During edits mapping, the new table will be populated and then read by the ER&S program.

The probability of a significant risk materializing is low because the system changes are minimal.

More detail about this issue can be found in Appendix C, project CA0456-SP28, Retaining Submitted Procedure and Modifier Codes.

Long Term Care Gap Analysis Results

This section provides an overview of the major gaps identified during the Long Term Care 835 analysis, the recommended solutions for those gaps, the systems impacted by the solutions, and the unique risks associated with the gaps and its solutions.

Mapping of Data Elements to State-Defined Formats

The HIPAA 835 transaction will change the data presented on the ER&S. Many fields on the current ER&S are not allowed on the HIPAA 835. New fields will be added to accommodate the HIPAA 835 requirements and balancing of the transaction.

The recommended solution for the issues identified with the 835 will result in HIPAA compliance and provider receipt of critical information. The LTC system will be modified to produce the HIPAA 835, the current non-covered pending claims report, and two additional non-covered reports – one listing the local EOBs, ICNs, and Detail Numbers, and the other displaying the Financial Summary information found currently on the ER&S.

The R&S program must be redesigned in order to implement this solution. Modifications to the provider billing software (TDHconnect) are also required.

There is some risk due to the complete redesign of the LTC system and Provider billing software. The impact if this risk materializes is high.

More information about 835 data mapping can be found in Appendix C, project CA0456-LTC19, R&S Functionality.

Balancing

The HIPAA 835 transaction requires balancing at the claim line item, claim header, and provider payment levels. The claims processing server and state fiscal system must capture and make available the reason and the amount of each claim payment reduction and/or increase. In addition, any non-claim provider level reduction must be captured and reported on the ER&S.

The recommended solution is two-fold. One part requires the LTC system to track all claim payment adjustments, such as Client Responsibility, in order to report these on the ER&S. The second part requires the State fiscal systems (TDHS and TDMHMR) to submit the reason for, and amount of, any payment adjustments to LTC via the Fiscal Interface.

The solution requires modifications in the following areas:

- R&S Program
- Interfaces
- State Fiscal Systems

There is risk due to the redesign of the ER&S and dependency upon the state system to implement the necessary changes. The impact if this risk materializes is high. Carefully timed and fully concurrent system changes with the LTC system and the state fiscal systems are critical for this solution.

More information about 835 balancing can be found in Appendix C project CA0456-LTC14, R&S Balancing.

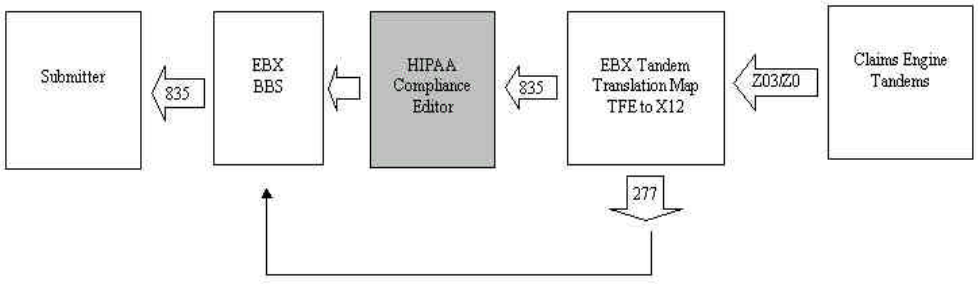
Summary

The ER&S will continue to be prepared in a state-defined format and sent to a clearinghouse for translation and delivery in a compliant format to providers. Supplemental files will also be sent that will include additional information on finalized claims. The claim processing systems must capture the amount associated with each payment adjustment. The local EOBs on the claim will be translated to compliant claim adjustment reason and remark codes that will be reported along with the associated amounts on the ER&S. Paper remittance advices will also report payment adjustment codes using the National Standard claim adjustment reason codes and remark codes.

In summary, the assessment of the 835 transaction reveals the need for new electronic remittance advice functionality. Provider, HHSC/DHS, and NHIC training will be needed regarding the new functionality provided by the applications.

The diagram shown below depicts the proposed flow of the electronic 835 from the TMMIS to the providers and the supplemental file containing additional information on the finalized claims.

ER&S Transmission



278 Health Care Services Review Request/Response

This section provides an overview of the 278 Health Care Services Review transaction. Business impacts are addressed and a recommendation for remediation is provided.

Purpose of the 278 Transaction

The purpose of the 278 is to accommodate the exchange of prior authorizations between providers and receiving entities. The 278 Implementation Guide supports the following business activities:

- Admission certification review request and associated response
- Referral review request and associated response
- Health care services certification review request and associated response
- Extend certification review request and associated response
- Certification appeal review request and associated response
- Dental referrals and certifications

Batch and real time transactions are supported by this standard. However, an interactive product cannot be implemented without a systematic method of approving a prior authorization (PA) request. The implementation guide does not mandate which method is required for a benefit area because some requests are difficult to process real time.

The following segments are the minimum required for the 278 – Request:

- Utilization Management Organization (UMO) Level
- Utilization Management Organization (UMO) Name
- Request Level
- Request Name
- Subscriber Level
- Subscriber Name
- Service Provider Level
- Service Provider Name
- Service Level
- Health Care Services Review Information

The following segments are the minimum required for the 278 – Response:

- Utilization Management Organization (UMO) Level
- Utilization Management Organization (UMO) Name
- Request Level
- Request Name
- Subscriber Level
- Subscriber Name
- Service Provider Level
- Service Provider Name
- Service Level
- Health Care Services Review Information
- Transaction Set Trailer

It is important to note that the 278 does not accommodate attachments. The proposed rule for electronic attachments is expected in the next 12 to 24 months with an anticipated effective date occurring after the required 278 implementation date.

Current Environment

A request for PA is received on paper, via fax, or on the phone. Paper PA requests are received often with a large amount of supporting medical documentation.

When NHIC receives a PA request via telephone, the decision is conveyed to the provider during the phone call and the PA online file is immediately updated. For paper PA requests, the decision is conveyed to the provider with a letter indicating the determination and any restrictions that could apply. The PA online file is updated with the appropriate information when the final decision has been made. Texas Medicaid does not currently support electronic PA requests. Electronic admission certification/extension and referral requests are not supported.

Gap Analysis

A comprehensive gap analysis was not performed for this transaction, because this function is not supported electronically in the TMMIS today. HIPAA mandates will require the ability to accept and process electronic PA requests.

The recommended solution is to have the clearinghouse accept the submitted transaction and return a generic response.

The impact of this solution is to the clearinghouse.

The impact if the risk materializes is low. Providers who submit electronic authorization request may expect a more robust response.

More detail about the exchange of prior authorizations between providers and receiving entities can be found in *Appendix D – Approach Document.*

Summary

In summary, NHIC is proposing to accept a 278 request but immediately return a generic response.

276/277 Claim Status Request/Response

This section provides an overview of the 276 Health Care Claim Status Request and 277 Health Care Claim Status Response. Business impacts are addressed and recommendations for remediation are provided.

Purpose of the 276/277 Transactions

The general purpose of the 276 Transaction is to allow a provider or authorized agent to request the status of a health care claim(s) previously submitted to a payer. The 277 Transaction allows the payer to respond with information regarding the status of the specified claim(s).

Data elements on the 276 transaction that may help the payer identify the requested claim include:

- Claim Service Date
- Claim Submitted Charges
- Claim Submitter Trace Number
- Dependent Demographic Information
- Dependent Level
- Dependent Name
- Information Receiver Level
- Information Receiver Name
- Information Source Level
- Internal Control Number
- Institutional Bill Type Identification
- Medical Record Identification
- Payer Claim Identification Number
- Payer Contact Information

- Payer Name
- Provider Name
- Service Line Date
- Service Line Information
- Service Line Item Identification
- Service Provider Level
- Subscriber Demographic Information
- Subscriber Level
- Subscriber Name

The 277 Transaction can also be used as a notification about health care claim(s) status, including front-end acknowledgments, or as a request for additional information about health care claim(s).

The following information is required in the 277 Response:

- Claim Level Status Information
- Claim Service Date
- Claim Submitter Trace Number
- Dependent Demographic Information
- Dependent Name
- Information Receiver Name
- Institutional Bill Type Identification
- Medical Record Identification
- Medical Record Information
- Payer Claim Identification Number
- Payer Contact Information
- Payer Name
- Provider Name
- Service Line Date
- Service Line Information
- Service Line Item Identification
- Service Line Status Information
- Subscriber Demographic Information
- Subscriber Name

Current Environment

Claim Status Inquiry (CSI) requests are initiated by a provider and a response is sent back by the TMMIS via TDHconnect. There are currently six different types of requests a provider can perform. They are as follows:

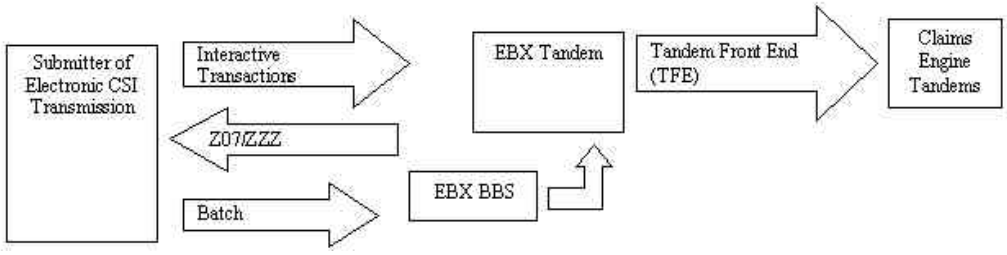
- **Batch Transmission Detail Request:** Claims batch ID is submitted and detailed information on all claims is returned in the response.

- **Batch Provider Claims Request:** Provider number, service date span, and claim status (paid, denied, in-process, all) are submitted, and detailed information on all claims meeting the criteria is returned in the response.
- **Batch Client Claims Request:** Client ID or trainee SSN, service date span, and claim status are submitted, and detailed information on all claims meeting the criteria is returned in the response.
- **Batch Claims Request:** Provider number and up to 99 ICNs are submitted, and detail on all claims is returned in the response.
- **Interactive Transmission Summary Request:** Claims batch ID is submitted, and a summary of the claims in the batch based on claim status is returned in the response.
- **Interactive Claim Request:** Provider number and a single ICN is submitted, and detail information on the claim is returned in the response.

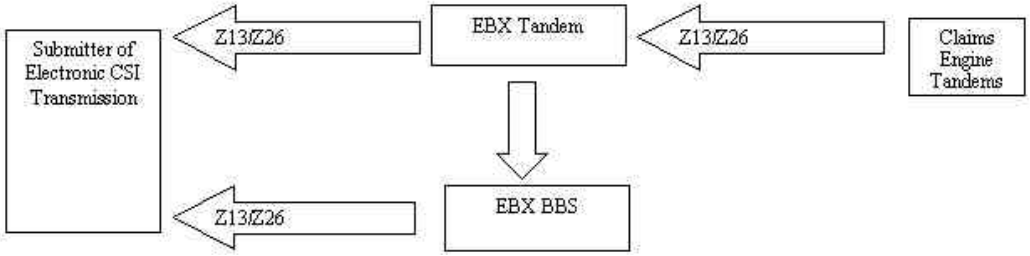
Currently there are two types of CSI responses: Transmission Summary Response and General Response. The Transmission Summary Response is returned when an Interactive Transmission Summary Request is submitted. The General Response is returned when all other CSI requests are submitted. The Transmission Summary Response contains the sum of accepted, paid, denied, and in-process claim counts and monetary amounts for the claim batch. The General Response contains claim header and claim detail information for each claim within the request criteria (ICN, Provider Claims, Client Claims, or Transmission Detail inquiry requests). Additional information may be included in the Extended Response Segment if requested by the provider.

The current flow of electronic CSI inquiry and response transactions are represented in the figure below.

CSI Transmission



Response Transmission



Acute Care Gap Analysis Results

This section provides an overview of the major gaps identified during the Acute Care 276/277 claim inquiry analysis, the recommended solutions for those gaps, the systems impacted by the solutions, and the unique risks associated with the gaps and their solutions.

More detail about the 276/277 gaps can be found in Appendix C, project CA0456-SP12, Claims Status Inquiry. Additional information regarding EOBs can be found in the Gap Analysis Section on Code Sets.

Batch ID Claim Status Inquiry Request

In the current system, providers can inquire on an entire batch of claims at one time. HIPAA requires at least a Patient Control Number (PCN) be supplied with each inquiry.

The recommended solution to this issue is to require the PCN on all CSI requests.

Logic to CSI will be modified to no longer support Batch Id inquiries. A provider may still request a CSI on a batch of claims by submitting each PCN and ICN for each claim within the batch.

The probability of a significant risk materializing is low, as system functionality is being reduced not added. There may be additional customer service calls as a result of the reduced functionality.

Mapping Issues and New Data Elements Required on the 277

Several data elements in the Acute Care's state-defined claims inquiry response file layout do not map directly to the 277. The recommended solution is to change the TFE to include the data elements needed so that the clearinghouse can prepare a compliant response.

The following areas are impacted by this solution:

- The claims inquiry server must prepare and load the changed TFE
- The EDI department must prepare the mapping instructions
- The clearinghouse must code the maps
- TDHconnect must be changed to load the data in the HIPAA-compliant format

There is some risk due to the number of system changes. Some provider and vendor training will be necessary. The impact if this risk materializes is moderate.

Long Term Care Gap Analysis

CSI transactions will be fundamentally different with HIPAA. The HIPAA CSI request supports only one type of request. Several fields will no longer be submitted with the request but new fields will be included. All local EOBs will be replaced by Claim Status Inquiry Codes.

The recommended solution is to accept and return the data allowed within the HIPAA-compliant 276/277 transactions. A supplemental file will also be sent with the response containing the noncovered information.

This solution requires significant modifications to the CSI functionality. ANSI providers will have to build additional capability into their systems in order to read the supplemental file.

There is some risk due to the number of system changes. Provider and vendor training will be necessary. The impact if this risk materializes is moderate.

More detail about the 276/277 issues can be found in Appendix C, project CA0456-LTC15, Claim Status Inquiry (CSI).

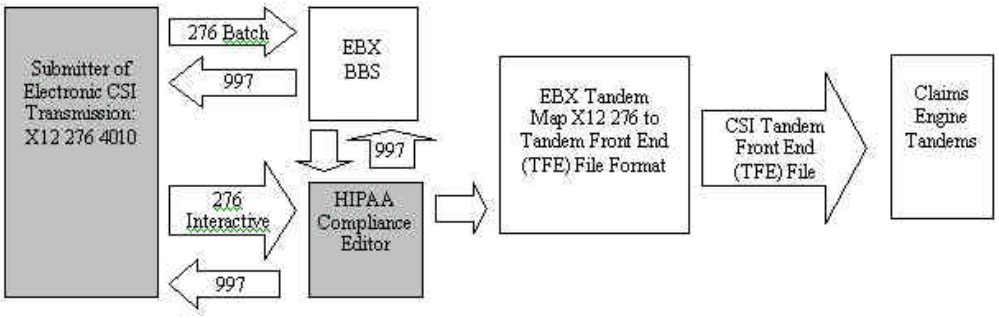
Summary

In summary, the assessment of the 276/277 transaction reveals the need for modified claims status request and response functionality. Provider, HHSC/DHS, and NHIC

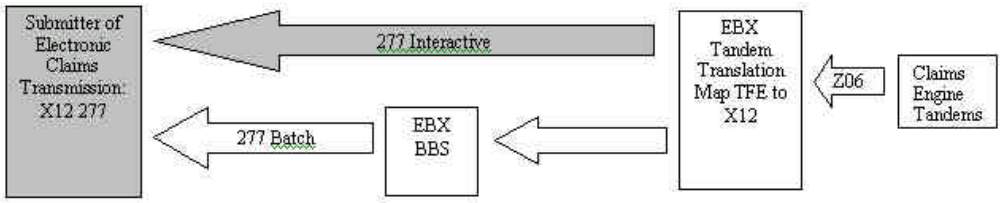
training will be needed regarding the changed functionality provided by the applications.

The proposed flow of the Claims Status Request and Response is depicted in the diagram below.

276 Claim Status Request Transmission



277 Claim Status Response Transmission



270/271 – Eligibility Benefit Request/Response

This section provides an overview of the 270 Health Care Eligibility Benefit Request and 271 Health Care Eligibility Benefits Response. Business impacts are addressed and recommendations for remediation are provided.

Purpose of the 270/271 Transactions

The purpose of the 270/271 Transactions is to allow submitters to determine whether eligibility information for a particular client is on file and to obtain necessary client

health care eligibility and/or benefit information. The 270 transaction is used by the provider to request verification. The 271 transaction is used to respond to the request.

The data available through the 270/271 is used to verify an individual's eligibility and benefits. For service limits, this transaction has the ability to show a given client's use of services, such as quantity used to date, but it does not contain related claim history. The 270/271 can be used to reserve benefits that are limited and request spend-down amounts to be deducted. The 270/271 transactions are designed to satisfy the needs of a simple eligibility status inquiry, or request more complex benefit amounts such as coinsurance, copays, deductibles, exclusions, and limitations related to a specific procedure. The simple eligibility status inquiry satisfies the minimum HIPAA requirement. However, the transaction sets are designed to allow for more elaborate responses. The HIPAA guide strongly encourages that detailed responses are supported to the maximum extent possible to meet the submitting and receiving organizations' business needs.

General/basic requests that can be supported include:

- Eligibility Status
- Maximum Benefits or Policy Limits
- Exclusions
- In-plan/Out-of-plan Benefits
- Coordination of Benefits Information
- Deductibles
- Copays

More specific requests include:

- Procedure Coverage Dates
- Procedure Coverage Maximum Amount(s) Allowed
- Deductible Amount(s)
- Remaining Deductible Amount(s)
- Coinsurance Amount(s)
- Co-payment Amount(s)
- Coverage Limitation Percentage
- Patient Responsibility Amount(s)
- Noncovered Amount(s)

The 270 Inquiry Transaction has defined the maximum data set that may be required by the receiver of the transaction to identify the client. That data set consist of the following four data elements:

- Patient's Member ID (Medicaid ID)
- Patient's First Name
- Patient's Last Name
- Patient's Date of Birth

If all four of the above data elements are present, a 271 response must be generated if the patient is enrolled. An inquiry to the system can be initiated if there is a reasonable amount of information present, even though all four of the above elements are not present. More search options could be made available, but a search option other than those listed above cannot be required. Provider information supplied in the 270 Inquiry should continue to be validated to ensure that the providers can legitimately send/receive eligibility information.

A 271 Response transaction must contain at least one Eligibility Benefit response or one Request Validation/Error response. The 271 Response transaction must return all data elements from the original 270-inquiry transactions that were used in the determination of the response. If specific data such as procedure code, diagnosis code, or ID numbers are submitted in the 270 transaction, an explicit response is not required if the system is not capable of returning specific data. However, the response cannot be rejected due to the presence of this additional information. In this example, the minimum compliant response, "Yes/No, the patient is/is not eligible," must be returned.

HIPAA mandates only the basic inquiry and corresponding response to determine whether or not a recipient is eligible.

Current Environment

Acute Care uses the Eligibility Verification system and TDHconnect software for eligibility verification using state-defined formats. Vendors can also submit eligibility verification requests using the EDIFACT format.

Long Term Care uses the Medicaid Eligibility and Service Authorization Verification (MESAV) application and TDHconnect software for eligibility verification using state-defined formats.

The current eligibility systems provide the capability to enter a single eligibility request interactively or up to 100 requests in a batch. Providers are required to enter the client's PCN or, if unknown, two of the following data elements:

- Full Name
- Date of Birth
- Social Security Number

The provider must also supply the eligibility date information. This may be a single date or a range of dates.

If more than one client exists with the information provided, a provider needs to narrow the search or contact NHIC Customer Service. To narrow the search, a provider may enter the following information:

- County

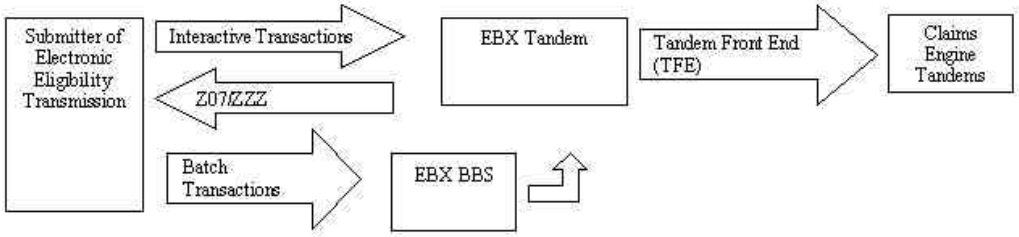
- City
- ZIP Code
- Sex

The following types of information are returned:

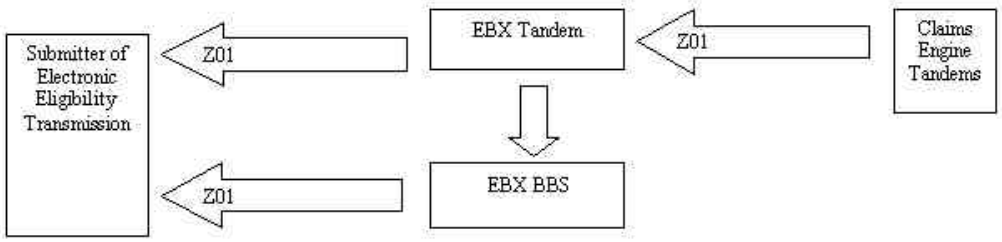
- Client
- Medicaid Eligibility
- CIDC Eligibility
- Medicare
- Lock-in
- Provider
- Prior/Service Authorization
- Pre-certification Information returned for Managed Care Clients
- Other Insurance
- Case Review
- Managed Care
- Benefit limitations

The flow of the eligibility inquiry and response in the current environment is given below.

Eligibility Transmission



Response Transmission



Acute Care Gap Analysis Results

This section provides an overview of the major gaps identified during the Acute Care 270/271 eligibility inquiry analysis, the recommended solutions for those gaps, the systems impacted by the solutions, and the unique risks associated with the gaps and their solutions.

More detail about the 270/271 gaps can be found in Appendix C, project CA0456-SP19, Eligibility Transaction Sets.

Internal Code Sets

Acute Care uses state-defined internal code values in five input fields that are different from the corresponding values in the HIPAA-compliant 270/271 transaction.

A crosswalk has been developed to translate from the Acute Care values in these fields to the HIPAA- compliant values.

Only the clearinghouse is impacted since the Acute Care system will not change.

The probability of a significant risk materializing is low, as no Acute Care system changes are needed.

Mapping Data Elements to the 270/271 Transaction

Several data elements in the Acute Care's state-defined file layouts do not map directly to those in the HIPAA-compliant file layouts. Furthermore, many new data fields will be added to the state-defined formats.

Mapping instruction will be provided to the clearinghouse to map the values in the HIPAA 270/271 to the correct TFE fields.

The impact will be to the clearinghouse to code the mapping. TDHconnect and the software used by Value Added Networks (VAN) will have to be changed to generate and process the data in the HIPAA-compliant formats.

There is risk due to the interfacing with TDHconnect and the VANs. Provider and vendor training will be needed. The impact if this risk materializes is moderate.

Data Not Covered in the 271 Format

Current business functionality is not supported by the HIPAA-compliant 271 format. Several data fields, including some prior authorization information that providers currently receive, are not contained within the HIPAA-compliant eligibility response format.

The recommended solution is to return a supplemental file along with the required 271 response. The supplemental file will contain the additional data that is not covered in the 271 format.

This issue impacts the eligibility server, the clearinghouse, and provider software that receives eligibility responses such as TDHconnect and Value Added Networks.

There is risk, as system changes are required in multiple areas. There will be provider and Vendor training and support until providers learn to access both files for needed information. The impact if this risk materializes is moderate.

Long Term Care Gap Analysis

The HIPAA 270/271 transaction requires certain information to be submitted on the request and limits the data that can be sent back on the response. Much of the current response data cannot be mapped to the HIPAA-compliant 270/271. This data includes Service Authorization, Level of Service, Client Responsibility, and Utilization information. It is also important to note that dates are the only LTC eligibility segment information returned.

The recommended solution is to accept and return the HIPAA-compliant 270/271 transactions. A supplemental file containing the non-covered data will be sent with every eligibility response file.

The solution has a major impact to the MESAV program. The program must be modified to return the new 271 transaction, as well as the new supplemental file. TDHconnect must be modified to submit and receive the new 270/271 transactions. This solution is an impact to ANSI providers as well, because they will have to build additional capability into their systems in order to read the state-defined file. The LTC system security validation process will be modified due to the new data contained in the 270 request.

There will be provider training and increased provider support until providers learn to access both files for needed information. There is some risk due to the system changes. The impact if this risk materializes is high.

More detail about the 270/271 issues are located in Appendix C, project CA0456-LTC16, Medicaid Eligibility and Service Authorization (MESAV).

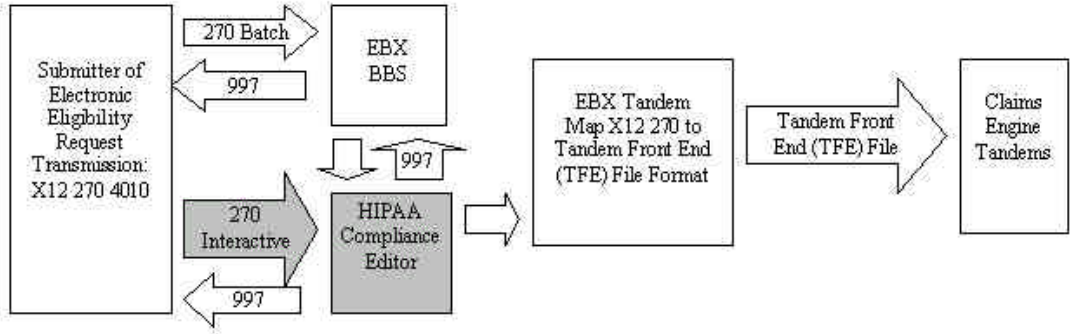
Summary

Assessment of the 270/271 transactions identified numerous data elements that will impact multiple files, screens, reports, and processes. Eligibility programs and the TDHconnect software need revision to accommodate additional search options and to be HIPAA compliant. Provider, HHSC/DHS, and NHIC training will be needed regarding the modified functionality.

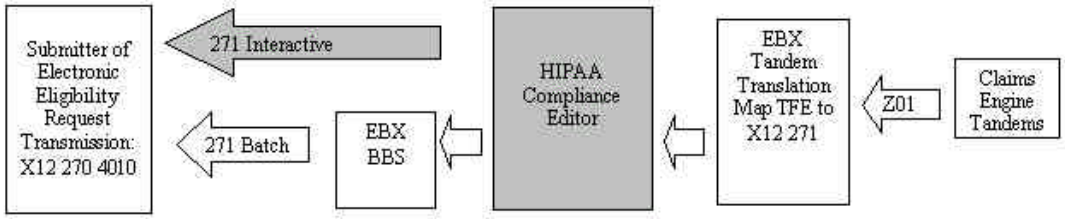
Appendix C, “SP19 Eligibility Inquiry/Response,” contains a diagram that illustrates the high level flow of the eligibility benefit request/response information from external trading partners into the TMMIS system.

The proposed flow of data for the Eligibility Request and Response is depicted below.

270 Eligibility Request Transmission



271 Eligibility Response Transmission



TDHconnect

TDHconnect is a software package that the state offers free of charge to providers to encourage electronic transmission of claims. The covered transactions produced and received by TDHconnect must be compliant at some point. Many of the gap solutions discussed previously have consequences for TDHconnect. Some of the proposed changes to TDHconnect include:

- X12N-compliant transactions will be produced and received for all covered transactions.
- The Medical Record Number and the Patient Account Number lengths will be expanded.
- The provider input screens will have a drop down box to select taxonomy codes.
- The TPR fields will be changed to populate the new TPR fields in the 837.
- Long Term Care will use all three claim input formats.
- Acute Care adjustments will be prepared with all of the appropriate fields populated.
- Eligibility inquiry and response will be changed to submit and receive compliant transactions. The supplemental files that accompany eligibility responses will be displayed on separate screens.

- Claim status inquiry and response will be changed to submit and receive compliant transactions. The Long Term Care supplemental file that accompanies a CSI will be displayed on a separate screen.
- Acute Care claim status inquiry by Batch ID will no longer be supported.
- The supplemental file that accompanies an ER&S will be stored and displayed on a separate screen.
- Claim, provider, and patient data will be converted to the new version of TDHconnect.
- Appeals submitted by the prior version of TDHconnect will be viewable.
- TDHconnect will be changed to support 50 details on professional and dental claims. The number of details on institutional clams will be decided during Business Design.

More detail about the TDHconnect gaps can be found in Appendix C, project CA0456-SP14.

Risks

Key - Low

- Moderate

- High

Acute Care Risk Assessment Table

Transaction Standard	Subproject	Impact	Risk	Comment
837	**Overall**			
	SP01 50/999 details			Impacts to interfaces Technically complex Testing effort is extensive Time remaining prior to mandated date

Transaction Standard	Subproject	Impact	Risk	Comment
	SP03 – Local Codes			Impacts 276/277 278, 835, 837 transactions Impacts systems, operations, business support, interfaces, providers and state program/policy Program policy changes may be needed Time remaining before mandated date Testing effort will be extensive Provider communication/publication timeline Requires providers to change how they bill
	SP04 Claim Types			Mapping instruction to derive Claim type
	SP05 Exceptions to Periodicity			Provider training and education
	SP06 Claim Header Dates			Mapping instruction for Clearinghouse
	SP07 CHSCN			State Program/Policy rules change required
	SP08 – Ambulance			Use of comment field may be questioned and may not be available at a later date
	SP11 TPR/TARS			Mapping instruction for Clearing House Provider training and education

Transaction Standard	Subproject	Impact	Risk	Comment
	SP17 National Modifier Codes			Impacts 276/277 278, 835 transactions Impacts systems, operations, business support, interfaces, providers and State program/policy Program policy changes may be needed Time remaining prior to mandated date Testing effort will be extensive Provider communication/publication timeline Requires providers to change how they bill
	SP18 New and Expanded Fields			Significant changes to System Time remaining prior to mandated date Testing effort will be extensive
	SP20 Authorization Local Code Issue			Complex crosswalk when mapping not one to one Risk of additional claim suspense
	SP21 Adjustments			Potential for additional claim suspense
	SP22 Enhancement Fields			Mapping instruction for Clearing House
	SP23 Old fields no longer used			Provider training and education
	SP24 Financial Payment Source Code			Mapping instruction for Clearing House
	SP25 Encounters			Keep current formats (HHSC has determined encounters are out of scope for this assessment)
	SP26 Rejected Response Format			Keep x12 version of current format
	SP27 Crossovers			Mapping instruction for Clearing House
	SP34 EBX 837 Mapping Issues			Mapping instruction for Clearing House

Transaction Standard	Subproject	Impact	Risk	Comment
276/277	**Overall**			
	SP37 EBX 276/277 Mapping Issues			Mapping instruction for Clearing House
	SP12 CSI Inquiry/Response			Mapping instruction for Clearing House Provider training and education
835	**Overall**			
	SP 35 EBX 835 Mapping Issues			Mapping instruction for Clearing House Provider training and education
	SP13 E R&S Redesign and Balancing			Significant system changes Must get Family Planning warrant information from State Comptroller
	SP15 SP16 EOB & EOPS Codes			Provider training and education
	SP10 Family Planning Funds Gone			Provider training and education
	SP28 Retain Submitted Procedure/Modifier Codes			Some system change required
Provider Software	**Overall**			
	SP14 TDHconnect			Significant system changes Time remaining prior to mandated date Testing effort will be extensive
270/271	**Overall**			
	SP36 EBX 270/271 Mapping Issues			Mapping instruction for Clearing House Provider training and education
	SP19 Eligibility Inquiry and Response			Mapping instruction for Clearing House
	SP30 Auth Fields on Eligibility			Supplemental file

Transaction Standard	Subproject	Impact	Risk	Comment
278	**Overall**			
	SP31 278 Transaction			Mapping instruction for Clearing House
Interface	Overall			
	SP32 Utilization Review Reporting			Manual effort to change rules

LTC Risk Assessment Table

Transaction Standard	Subproject	Impact	Risk	Comment
837	**Overall**			
	LTC01 Claims (837)related issues			Significant modifications to functionality, claim servers, processing, payment determination, and reporting Loss of data dependent on business rules Addition of new data Provider training and education
	LTC02 Header Adjustments (HADs)			Modify Adjustment Server to not allow HADs
	SP03 Service Group not submitted			Needed for primary claim processing Will be derived after HIPAA New dependency on Provider Service Group information
	LTC04 Budget Number not submitted			Loss of functionality for Budget Numbers other than '1' or '2' Assumption of Budget Number '1' may lead to claim payment from incorrect fund source
	LTC05 Leave Days			Will no longer receive, not used in claims processing
	LTC06 Claim type not submitted			Modify claims processing Can be mapped by clearinghouse
	LTC07 Procedure and item code			Loss of functionality affecting claim service and payment determination This information will now be derived
	LTC08 Adjustment Detail Reference Number			Modification to claims processing No loss of functionality

Transaction Standard	Subproject	Impact	Risk	Comment
	LTC09 Billing Codes			New dependency on reference table information Will now be derived based on claim data and system data
	LTC10 Billed Unit Rate			Variable rate functionality affected Will now be derived based on other claim information
	LTC11 Client PIN			Not currently used in the LTC system
	LTC12 Number of Details			Modification to claims processing Affect on peripheral programs and system performance No anticipation of providers utilizing the HIPAA maximum
	LTC13 Program Type			Modification to claims processing
	LTC17 Test Production ID			Minimal change to functionality No business need for current functionality
	LTC18 Billed Applied Income Copay			Modifications to claims processing Not used to determine payment
	LTC20 Trace Sequence Issue			Mapping instructions for clearinghouse
	LTC21 Field Size Issue			Modification to TFE, database and reports for affected fields No expectation that providers will utilize the maximum allowed by HIPAA
	LTC24 Detail Count not available on Claim			Minimal modifications needed to calculate this value that will not be sent to the LTC system Not used to determine payment

Transaction Standard	Subproject	Impact	Risk	Comment
	LTC26 Line Item control Number			Modification to TFE and database and reports Not used to determine claim payment
	LTC28 Decimal Fields			Modifications to claims processing and logs
	LTC29 Inappropriate Qualifiers			Modifications to claims processing and logs
	SP34 EBX 837 Mapping Issues			Mapping instruction for clearinghouse
276/277	**Overall**			
	SP37 EBX 276/277 Mapping Issues			Mapping instruction for clearinghouse
	LTC15 Claim Status Inquiry			Mapping instruction for clearinghouse Modifications to CSI program Provider training and education
835	**Overall**			
	SP 35 EBX 835 Mapping Issues			Mapping instruction for clearinghouse
	LTC14 R&S Balancing			Significant system changes Must balance based on fiscal file from DHS and MHMR and system data
	LTC19 R & S Functionality			Significant modifications to TFE and servers; Mapping instruction for clearinghouse; Provider training and education.
	LTC25 No local EOBs			Modifications to functionality; National codes will be used; Local EOB codes will be provided separately; Provider training and education
Provider Software	**Overall**			

Transaction Standard	Subproject	Impact	Risk	Comment
	SP14 TDHconnect			Significant system changes Time remaining prior to mandated date Testing effort will be extensive
270/271	**Overall**			
	SP36 EBX 270/271 Mapping Issues			Mapping instruction for clearinghouse Provider training and education
	LTC16 Medicaid Eligibility Service Auth Verification			Significant modifications to functionality; Additional MESAV information not part of HIPAA transaction will be sent in a separate file; Provider training and education.

Recommendations

Trading Partners

HHSC/DHS can encourage the use of the various transactions by publishing the user or companion guides that trading partners would need to implement the standards. These user or companion guides are not a HIPAA requirement, but many of the data elements are conditional and based on specific business situations, so these guides are necessary to provide trading partners with the proper situational values to use. Publication and distribution of these guides will exhibit HHSC/DHS commitment to its providers by offering an electronic option for the additional transactions.

Development Environment

Several of the HIPAA implementation solutions require changes to the data models used by the processing systems. Since each system, both Acute and Long Term Care, will need to continue to maintain its production code during the HIPAA development and testing period, additional Model Office environments will need to be set up for the HIPAA development. This means that there will be separate HIPAA copies of the source and object code for each system. There will also need to be separate test and Model Office databases to allow the testing of the HIPAA changes. In addition to the changed data model, there will be reference data changes in the HIPAA data environments as described in the next section of this report.

As changes are made in the current environments, the code or data changes will have to be migrated to the HIPAA environment. The HIPAA compliant systems will have

to be re-tested as each change is made to ensure that the HIPAA compliant code also incorporates the new change. Changes to the current systems should be minimized to reduce the risk and effort involved in migrating and testing the changes. Minimizing the changes to the current applications during HIPAA development will reduce the risk of noncompliance and errors.

Testing

A crucial phase in the implementation of the HIPAA X12N transactions will be the time invested in testing. HHSC/DHS is encouraged to begin identifying resources, both internal to the state agencies and external trading partners that can be used to test the systems and workflows involving the impacted HIPAA X12N transaction processes.

The Workgroup for Electronic Data Interchange (WEDI) is an organization comprised of health care industry representatives whose mission is to encourage the adoption of electronic commerce. WEDI has established a task group called the WEDI HIPAA Strategic National Implementation Process (SNIP) to aid the health care industry to achieve successful compliance with HIPAA administrative simplification. SNIP has published a schedule for implementation of the standard transactions. The purpose of this proposal was to establish a priority order among the transactions and to provide some dates as a baseline for the organization's project plans. The following is the proposed schedule that takes the one-year HIPAA extension into consideration.

Transactions	Testing begins	System Readiness testing begins	Required compliance readiness date
837	April 1, 2002	July 1, 2002	October 16, 2003
835	April 1, 2002	July 1, 2002	October 16,2003
278	April 1, 2003	July 1, 2003	October 16.2003
276/277	January 1, 2003	April 1, 2003	October 16, 2003
270/271	July 1, 2002	October 1, 2002	October 16, 2003

This schedule implies a phased approach by transactions for remediation, testing and implementation that calls for remediation design and coding for claim input and electronic remittance transactions to be completed by April 1 of 2002. Such a schedule would have allowed all organizations to get ready for conversion and to conduct more thorough quality assurance testing. Clearly it is now too late to follow a similar schedule. This timetable reinforces the position that the TMMIS is well behind schedule and that remediation must begin immediately to prevent additional risk of not being complaint by October 16, 2003.

Ongoing Participation in HIPAA

HIPAA has set into motion a means for constantly increasing the capability for the healthcare industry to take advantage of technology and increase efficiency by standardizing the exchange of information electronically. HHSC/DHS need to be aware of all the activity related to upgrading and expanding the electronic standards for healthcare information. Monitoring activity associated with the Designated Standards Maintenance Organizations (DSMOs) can do this. The Web site http://aspe.os.dhhs.gov/admnsimp/ is a good starting point for an overview of HIPAA administrative simplification, and the site http://www.hipaa-dsmo.org/ has information about the DSMOs. Each standard-setting organization has a process in place to submit requests for updates. HHSC/DHS can take an active role defining updates to the transactions where a current or future business need can be enhanced with the additional capability that the update would afford.

Code Sets

Overview

This section provides an overview of the Code Set requirements mandated in the final Transaction and Code Set rule. Business impacts are addressed and recommendations for remediation are provided.

One of the most widely supported areas of HIPAA legislation is the standardization of code sets for health care procedures and diagnosis codes. The most significant impact of standardization is embedded in the current use of these code sets and the local variation that exists in almost every organization. While some local variation is the result of continued use of outdated code set values, much of the variation is designed to overcome gaps in national standards or to drive special internal adjudication processes. Elimination of these local codes can potentially cripple current system and business processes. During the Gap Analysis, a comparison was made between the code sets currently used and those of the nationally recognized standard code set mandated by HIPAA. This review included the impact of eliminating local procedure codes, modifiers, EOB and EOP messages, as well as addressing the gaps between the internal code sets listed within the Implementation Guides.

Standards

Medical Code Sets: The code sets established for the identification of medical services are currently in widespread use, and the choice of those standards is not an issue. They include the following:

- Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes—Incorporates the AMA's CPT codes as level 1 HCPCS codes
- International Classification of Diseases (ICD-9) Diagnosis Codes
- National Drug Code (NDC)

External Code Sets: These code sets consist of HIPAA claim-specific adjustment reason codes, claim category codes, and claim status codes. The existing EOB and EOP codes have been cross-referenced to the external code sets. The national code set values are much less specific than the EOB or EOPs used in Texas Medicaid processing. The major business issue associated with these values is their lack of specificity. If only the national standard codes can be passed to the provider, helpdesks will be overwhelmed with requests for assistance and expansion of these assistance centers will be needed.

Internal Code Sets: Approximately 70 internal code sets containing close to 3,000 code set values are identified in the transaction Implementation Guides. A significant percentage of these internal code sets will require changes. Cumulatively, the effect of the HIPAA requirements for internal code set values on the TMMIS is substantial. A detailed comparison of code set values is included in *Appendix B - Code Set Mapping*.

Approach

For the Acute Care gap assessment of code sets, cross-references were performed on those code sets where reliance on local codes is dominant. The impact to current business processes, systems, and operations was determined, and workgroups were formed to begin to develop a recommended approach to address the issues. For Medical Codes, a cross-reference of local procedure codes and modifiers was completed. For the External Code Sets, two cross-references were developed. The first was a cross reference of local EOB/EOPs codes to Claim Adjustment Reason Codes and Remittance Remarks codes, and the second was a cross-reference of local EOPs codes to Health Care Claim Status Category Codes and Health Care Claims Status Codes. The Internal Code Sets cross-reference was completed as part of the transaction maps.

The Program Policy group was assigned the task of determining the number of local procedures codes on file, the status of those codes, and the frequency they were billed over a set period of time. They determined that a total of 4,194 local procedure codes/type of service combinations were on file. Of those, 1,978 are active codes, and 2, 216 are discontinued codes. The discontinued codes were not reviewed for impact or mapped to national codes. Next, the Program Policy group categorized the codes by the type of gap.

Based on preliminary review, the 1,978 active local codes fall into the following types of gap:

Type of Gap	Estimated Number of Codes
1. Discontinue (end date) local code – national code already in use	An estimated 13% of active local codes (257 codes)
2. Discontinue (end date) local code – code no longer necessary	An estimated 5% of active local codes (104 codes)
3. Discontinue (end date) local code – adopt national code and develop policy	An estimated 49% of active local codes (975 codes)
4. Discontinue (end date) local code – no national equivalent other than unlisted code (manual review)	An estimated 11% of active local codes (210 codes)
5. Discontinue (end date) local code – address processing considerations	An estimated 14% of active local codes (284 codes)

Type of Gap	Estimated Number of Codes
6. Cross reference national code to local code for claims processing	An estimated 5% of active local codes (101 codes)
7. Discontinue (end date) local code – no HCPCS equivalent, but maps to NUBC revenue code	An estimated 2% of active local codes (31 codes)
8. Evaluate for Atypical service status and continue use of local code	An estimated 1% of active local codes (16 codes)

Appendix B – Code Set Mappings contains the crosswalks completed for local procedure codes and local EOPs and EOB codes to the National Standards for these codes.

For Long Term Care a different approach was taken. DHS/MHMR performed the cross-reference effort. Joint workgroup sessions were held to develop the approach to be taken to resolve the gaps surrounding the loss of local codes.

Findings

The TMMIS currently uses local codes in the following areas:

- In the submission of medical services for payment
- In the explanation of claim adjudication
- In reporting the status of the claim, and in several of the internal data elements

The TMMIS must be able to accept and return the standard codes that will be submitted on the 837 for medical services as well as respond on the 835 with the standards for explanation of benefits or on the 277 with standards codes for responding to a 276 claim status inquiry. Internal data elements, like client sex that have standard values different from those currently being used, must also be addressed by the TMMIS.

Acute Care Gap Analysis Results

Local Procedure Code Gap Analysis Summary

This section provides an overview of the major gaps identified during the local procedure code analysis, the recommended solutions for those gaps, the systems impacted by the solutions, and the unique risks associated with the gaps and their solutions.

Local Procedure Codes No Longer Valid

Local procedure codes for medical services will no longer be accepted on claims. Currently, the Acute Care system performs editing, auditing, pricing, and reporting of claims that rely on local procedure codes.

The proposed solution is to use the following options where applicable:

- Discontinue (end date) the local code and adopt the national code.
- End the local code where it is not currently used in claims processing and does not require mapping.
- Cross-reference the national code and/or other claim information to a local code for claims processing.

The mapping to new codes will affect servers that make processing decisions based on local codes and reports or extracts that group or filter data based on local procedure codes. The impacted areas include edits, audits, pricing, prior authorization, STAT, and numerous claim-based reports.

Many state policy decisions must be effectuated downstream from the actual decision to map the local code to a national code. Almost the entire Policy Adjudication Manual needs to be restructured and rewritten with guidelines specific to the new codes and how they will be used. Medical policies must be drafted and approved by the state and then written as final policies, which will update the Medical Policy Manual. The entire Texas Medicaid Provider Procedures Manual (TMPPM), TMPPM-THSteps Manual, and the CSHCN Provider Manual must be rewritten with the changed policies and new codes. Additionally, the Program Policy manual known as Policy Interpretation must be rewritten for those policies that will change due to the cessation of local codes. In addition to these major policy documents that will change, there will be changes to SURS reporting, STAT reporting, downstream reports used by other agencies beyond HHSC and NHIC, provider system changes, and provider education materials changes. All of these changes must be completed in a short period of time before October 16, 2003 and in many cases, must be completed prior to March 2003. These changes are required in these time frames in order to notify providers in a timely manner of the changes they will need to make to their own billing processes and systems. There is risk that the full impact to down stream initiatives and reporting such as STAT bucketing will not be understood until after the new codes are in use. The impact if these risks materialize is high.

More detail about this issue can be found in Appendix C, project CA0456-SP03, National Standard Procedure Codes Required for Claims Submission.

Authorization Issues

Some authorizations are approved for services extending three years into the future. Currently one of the criteria used to match claims to authorizations is procedure code. If the authorization contains a local code and the claim now carries the national code, the match logic will not recognize the authorization as valid and the claim may deny.

Several different solutions are being recommended and may be employed to solve the issue with one or more of the 1,974 local codes that are being replaced.

- Identify authorizations with local codes and add corresponding details with the equivalent national code for each detail with a local code.
- Suspend selected claims that require an authorization if an authorization for that patient for that time period is on file, but a match cannot be made between the procedure billed and the procedure previously authorized.
- Allow the edit server to employ a cross-reference that allows selected procedures to be considered a match for selected procedures on the authorization.

A new server may be needed to perform a cross-reference and add details to existing authorizations. The edit server match process may be impacted. All the operational areas that deal with authorizations and respond to provider questions regarding authorizations and authorization matching may be impacted.

Significant risks exist with the design and implementation of the cross-references. Providers may not be paid promptly for procedures that were authorized using local codes. There is also a risk of increased provider calls to the customer service areas. This issue may require additional temporary personnel in the department that enters authorizations. The impact if these risks materialize is high.

More detail about this issue can be found in Appendix C, project CA0456-SP22, Authorization – Local Code Issue.

Local Procedure Codes Mapped to Revenue Codes

Several local procedure codes were mapped to revenue codes. A few of the codes were for stand alone renal dialysis facilities that currently are allowed to bill on professional claims. Other codes that mapped to revenue codes were for outpatient facilities. Currently, TDHconnect, Viking, and FormWorks capture procedure codes only on outpatient claims.

The recommended solution is for renal dialysis facilities to submit institutional claims if they need to bill using revenue codes. Another part of the solution is for TDHconnect, Viking, and FormWorks to allow revenue codes and procedure codes to be input for outpatient claims.

Outpatient providers as well as TDHconnect, Viking, and FormWorks will be impacted.

There is risk due to the system changes. The impact if this risk materializes is high..

Impact of Code Decisions on SURS Reporting

The Surveillance and Utilization Review System (SURS) reports may contain data for periods of time before and after the replacement of 1,978 local procedure codes

with national standard procedure codes. The reports will require updates to maintain an accurate comparison between the time periods.

The recommended solution is for the SURS data analysts to update the control tables where needed to include the old and new codes so that the utilization review will be as consistent and accurate as possible.

The primary impact is to the SURS operations team.

Additional staff may be required to update the profile rules in a timely fashion. This includes adding the codes and validating, and after the implementation, another high level of effort is required to remove the codes and validate the changes. The impact if this risk materializes is low.

More detail about this issue can be found in Appendix C, project CA0456-SP32, Local Procedure Code Changes and Surveillance and Utilization Review System.

Summary of Acute Care Local Procedure Code Gap Analysis

The following chart summarizes the scope of the system changes required to change from local to national procedure codes.

Areas Affected by Local Codes	Impact to Code and Records
TARS BTAR03	42 local procedure codes require coding change
Reference Procedure code reformatting (conversion), subsequent procedures, and TOS Autoplug	Requires table changes to end date 1,934 records Add new procedure codes
Editing/Auditing Groupings and Procedure Requirements	Possible table changes affecting 61,357 procedure code records or ranges Update edit/audit reference tables
Pricing Level 1 and Level 2 Pricing and PPI Procedure Code Exclusions	Requires table change to end date 35,190 procedure code records or ranges. Three local codes require coding changes in the pricing 1 server. Update pricing methodology to account for differences in provider types and/or modifiers
Vision21/AHQP Reporting Family Planning Reports and Extract, History Reports and Extract, Home Health Report, ImmTrac, Medlogs (Institutional Reimbursement), MSIS, STAT, SURS,	1,015 codes require possible coding changes Possible table changes to 2,083 records

Areas Affected by Local Codes	Impact to Code and Records
TDHvision predefined reports, and THSteps Extract	

Refer to Appendix G for further details summarizing the scope of the system changes required to change from local to national procedure codes.

Long Term Care Gap Analysis of Billing Codes

Local Billing Codes will no longer be accepted on HIPAA-covered claims.

The proposed solution is for LTC to derive the local Billing Code based on data submitted on the claim and data within the LTC system. The derivation process will require significant modifications and several new reference tables. Using the new reference tables and system data, a new process will read the claim data, including HCPC and/or Revenue Code, Place of Service, and Taxonomy, to determine what Service Code to plug on the line item. The local Billing Code will be derived from this information and used in claims processing.

The derivation process provides the ability to continue processing with local billing codes, but requires extensive changes within LTC. The LTC changes affect the following areas:

- The new pre-claim servers derivation process
- Claim servers
- LTC policy
- Pricing
- Retroactive adjustment server (retros)
- PSWin
- Reports
- Interfaces
- Reference tables

The risk associated with this solution is high. The derivation process is completely dependent upon the new reference tables being able to point to one unique local Billing Code. If this is not possible, the number of claim rejections/denials will increase. The derivation process requires the system data to be kept up-to-date in order to avoid additional rejections/denials. All of this is dependent upon the State giving NHIC the necessary data for these new reference tables. There is also an impact to the duplicate editing process as it may not be able to determine true duplicates if multiple national codes point to one local billing code. The timeframe is short, which increases the risk based upon the amount of code cross-referencing and table building that needs to be done. New reference data will need to be maintained by both the State and NHIC and regular monitoring of national code changes will need to occur.

More information about the use of Local Billing Codes can be found in Appendix C, project CA0456-LTC9, Billing Code.

Gap Analysis for Local EOBs and EOPs

TMMIS Local EOB Code Gap Analysis Summary

This section provides an overview of the major gaps identified during the TMMIS local EOB code analysis, the recommended solutions for those gaps, the systems impacted by the solutions, and the unique risks associated with the gaps and their solutions.

More detail about the EOB/EOPs gap analysis can be found in Appendix C, project CA0456-SP15, National Standard EOB/EOPs Codes on ER&S (835) and Claims Status Inquiry (277), and CA0456-LTC25, EOBs.

National codes on ER&S (835)

National standard codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) must be used on the ER&*S* (835). These codes are used to inform providers regarding how their claim was processed.

The proposed solution is to process, claims using EOBs in the same way as they are used today. The TMMIS will continue to display EOBs on all windows and reports. National standard codes (CARC/RARC) will be reported on the ER&S (835). In addition to the ER&S, a supplement file that conveys the local header and detail EOB codes will be returned.

In addition to the ER&S process provider software, including TDHconnect, that receive the ER&S and the supplemental file will be impacted. An additional reference file must be created and maintained that links an EOB to an associated CARC and RARC.

The risk associated with this issue is moderate. There may be additional EDI Technical Helpdesk and Customer Service calls until providers learn how to access and use the supplemental file information.

Family Planning Funds Gone

Acute Care family planning providers currently receive an EOB message (30000) on the ER&S when their claim is approved, but no money is paid because the budget for the Family Planning Program is exhausted.

The proposed solution is to send a national remittance advice code (B5) on the ER&S when the budget funds are exhausted. EOB 30000 will be reported on the supplemental file provided at the same time as the ER&S.

The main impact is on providers who will have to learn the meaning of the new code.

The risk associated with this issue is low. Since the explanation for the new message is not as specific as the current local EOB, there is some risk of increased call volume.

More detail about this issue can be found in Appendix C, project CA0456-SP10, Family Planning Funds Gone Status.

CSHCN/Medicaid Dual Eligible Claims

Providers that have a separate nine-character Texas Provider Identifier (TPI) for their CSHCN claims currently are required to report that Medicaid denied certain procedures on their CSHCN claim for those services. The provider first bills using their Medicaid TPI, and, then, based on certain local EOB codes being returned on the remittance advice, they re-bill the details that CSHCN will pay only after a Medicaid denial. Under HIPAA, they will not get the local EOB codes on their ER&S, and there is no place to put an EOB code on the CSHCN 837.

The proposed solution is for the Acute Care system to split the claim and change the two character suffix on the second claim to a matching suffix for CSHCN while keeping the seven character base TPI the same. With this method, the provider will be paid immediately for the CSHCN portion of the claim.

The primary impact of this solution is to the program split server that will have to identify the correct provider TPI suffix to put on the CSHCN claim.

There is a risk that the program split server will not be able to uniquely identify an acceptable TPI suffix for the CSHCN portion of the claim. In those cases, the CSHCN payable procedures will be denied on the Medicaid claim, and the provider will have to file a separate CSHCN claim on paper with a copy of the Medicaid remittance advice attached.

More detail about this issue can be found in Appendix C, project CA0456-SP07, CSHCN Issues.

National Codes on Claim Status Inquiries (277)

National standard codes, Claims Status Category Codes (CSCC), and Claim Status Codes (CSC) must be sent on the 277 claims inquiry response. These codes are used to inform providers of the status of their claims.

The proposed solution is to process claims using EOPs and EOBs in the same way as they are used today. The TMMIS will continue to display local EOPs and EOBs on all windows and reports. National standard codes (CSCC/CSC) will be reported on the Claim Status Response (277). In addition to the 277, a supplemental file will be created for Long Term Care.

The CSI process will be impacted. An additional reference file must be created and maintained that links each EOP and EOB with a CSCC and CSC.

The risk associated with this issue is moderate. There may be additional customer service inquiries until providers learn how to use the new CSCC and CSC codes returned by the 277 transaction. Long Term Care providers must be trained to access and use the supplemental file information.

Internal Code Sets

Each internal code set within each transaction was studied to see how it was used in the current system. The values in the transaction Implementation Guides were then mapped to the current values to identify any values that could not be cross-referenced from one old value to one new value. Any issues were documented as gaps and considered in the subproject dealing with that subject area. Project SP24 in Appendix C deals specifically with the mapping of the claim filing indicator.

Summary

The impact of HIPAA cascades across almost every business function, process, and transaction. The type of impact varies from a complete restructuring to very subtle changes. Changes resulting from elimination of local codes impact not only the TMMIS and providers, but also affect how programs are managed and could have a substantial impact on the Medicaid budget. Because the impact of code set standards is so large, discussions have begun on those issues that affect program management.

Interface Files

Overview

For purposes of the HIPAA assessment, a third-party interface is defined as any entity with which we trade data, whether we are the receiver or sender. This section lists major interfaces and the impact HIPAA will have on each.

Approach

Each interface was evaluated to determine if it was a covered HIPAA transaction. Then, each interface was evaluated in comparison to each HIPAA subproject to determine if the gap solutions from that project had an impact on the interface. The identified impacts, which will be evaluated further in business design, include impacts either to the format or to the data content of each interface.

Acute Care Gap Analysis

Medicare Intermediaries - We currently receive crossover claims from Trailblazers, Palmetto, and Mutual of Omaha. We will be required to receive 837 transactions rather than our current NSF and UB92 file formats.

Other Insurance Carriers - In a "pay and chase" situation, the TPL unit submits post-pay bills to other insurance carriers. Currently these bills are submitted on paper. If a decision is made at a later date to submit electronically, the system will need to be changed to generate the bills using the 837 transaction.

The Acute Care system exchanges interface files with other state agencies, other TMAS partners, and a few other entities. A list of these interface files can be found in *Appendix F - List of Interface Files*. Several of the interfaces are affected by one or more of the HIPAA analysis subprojects, and those impacts are summarized in the charts in Appendix G.

Long Term Care Gap Analysis

Long Term Care interface files are impacted by HIPAA as a result of changes to field sizes, incorporation of new fields, and loss of current fields. The state entities that receive, or send, these interfaces are also impacted.

Provider Interface

The Long Term Care system receives provider data from DHS/MHMR via this interface. Several different records are sent via this interface including Provider Service Group, Provider Budget, and Provider Rate.

Provider Service Group

It has been determined that new edits would need to be implemented that would verify that every Provider number has at least one Service Group. In addition, an edit may be required that would limit providers with multiple Service Groups to two—a combination of Service Groups 3 and 7, or a combination of Service Groups 1 and 9.

It has also been determined that the Provider Service Group record would also need to incorporate effective dates.

Provider Budget Interface

It has been determined that a new edit would need to be implemented that would limit the valid Budget Numbers being sent to a value of '1' or '2' only.

Provider Rate

It has been determined that a new edit would need to be implemented that would ensure that the Unit Rate does not exceed the HIPAA maximum.

Service Authorization Interface

The Long Term Care system receives client data from DHS/MHMR via this interface. Several different records are sent on this interface including Client. The Client Record includes the Client Name information. Currently, the client suffix is appended to the Client Last Name. HIPAA requires that when sent, the suffix be independent of the last name. Therefore, it has been determined that the Client record may need to be changed to send the information in separate fields.

SAVERR

The Long Term Care system receives client data from DHS/MHMR via this interface. The client record contained within this file includes the Client Name information. Currently, the client suffix is appended to the Client Last Name. HIPAA requires that when sent on a covered transaction, the suffix be independent of the last name. Therefore, it has been determined that the Client record may need to be changed to send the information in separate fields.

Processed Claim Interface/Miscellaneous Claims Interface

The Long Term Care system sends processed claim information via these interfaces. Various claim data elements are sent including Adjustment Detail Reference Number, Paid Units Count, and Client Control Number. Due to solutions described earlier, these fields are changing and, therefore, this interface must also change. The following subprojects affect this interface:

- Adjustment Detail Reference Number
- Maximum Number of Details
- Field Size

Reference Files (Code Tables)

The Long Term Care system receives updates to several reference files currently via CARTS and then through the PSWin application. An outstanding project will automate this functionality by creating interface records containing the data. Either way, the processing of this reference data is impacted. Various tables will have effective dates added to them (that is, Billing Combination and Billing Code). New data may be added to other tables. Edits will need to be implemented that ensure that the new data adheres to Business Rules.

Summary

Several of the gap solutions will have an impact on interface files that will have to be evaluated during business design. While the interfaces are not covered transactions, the field size changes will cause the formats of some of the interfaces to change. Each affected interface will have to be evaluated to see if the data content changes require other changes in the interface or the systems that use the interface.

Provider Communications

Health Insurance Portability and Accountability Act (HIPAA) Provider Education and Communication Plan

There are two phases to this education and communication plan. The first phase involves provider notification and awareness. Phase two focuses on detailed provider education, vendor education and testing, and TDHconnect testing and deployment. In addition to the provider community, there are numerous stakeholders impacted by the implementation of HIPAA. This plan includes all of these to ensure communication and coordination of activities:

- Providers
- Professional associations
- State agencies
- Billing vendors
- HMOs
- Medicare carriers/intermediaries (Palmetto, Mutual of Omaha, Trailblazers)
- TMAS contractors
- NHIC
- Provider Advisory Council
- Vendor Council

Definition of Stakeholders

Providers

The provider group includes traditional Medicaid, managed care, CSHCN, long-term care, nursing facility, and family planning Title V, X, and XX providers.

Professional Association

The professional association group represents professional associations that have providers (as described above) as members. This includes statewide associations, as well as local and county organizations and medical societies.

State Agencies

State agencies such as TDH, DHS, TCB, ECI, TEA, PRS, and MHMR are impacted by the implementation of HIPAA. With the assistance of HHSC, other state agencies will be added to the list as necessary.

Billing Vendors

Billing vendors are entities that submit claims to NHIC on behalf of a provider of service. This includes billing services as well as THIN of BCBS. Billing vendors also includes providers that "direct submit" to NHIC using vendor specifications, not TDHconnect.

HMOs

HMOs participating in Medicaid managed care are impacted by the implementation of HIPAA. They are included in notification activities so that they are aware of information being provided to the provider community, and are informed on file interfaces for Compass21 as it relates to HIPAA transaction/code sets.

Medicare Intermediaries/Carriers

Medicare intermediaries/carriers, stakeholders, such as Mutual of Omaha, Trailblazers, and Palmetto, are included in notification activities so that they are aware of information being provided to the provider community, and to coordinate testing efforts and file interfaces so that they are in accordance with HIPAA requirements.

TMAS Contractors

TMAS contractors must be made aware of information given to the provider community. They frequently have interface with *Compass21* that must be compliant.

Provider Advisory Council

The Provider Advisory Council was developed during Compass21 implementation and is composed of representatives from major professional associations, state agencies, and providers enrolled in the Texas Medicaid Program. This council will again be used to assist in getting information out to the provider community, providing guidance and direction, to NHIC and HHSC/TDHS on the type of information needed. They assist in identifying the provider community and make recommendations for or may be directly involved in TDHconnect testing. We anticipate that this group will meet in the first quarter of 2003.

Vendor Council

This group is composed of billing services/vendors that submit claims electronically to NHIC on behalf of providers. Like the provider advisory council, they assist us in getting information out to other vendors, provide feedback on training and assistance needs, and guidance on what difficulties may be encountered as specification changes are made for HIPAA. We anticipate that this group will meet in the first quarter of 2003.

The Communication plan will be carried out in two phases:

- Communication/Notification
- Education/Testing/Deployment

In addition to the implementation activities described elsewhere, the Operational Readiness Plans is developed so that the NHIC staff that support providers and vendors are prepared to assist with issues that may arise after implementation. The operations leadership of areas that will be most impacted are working to put plans in place to handle issues or concerns that may arise.

The following information identifies major activities associated with the key milestones.

The Communication/Notification Phase

The Communication and Notification Phase will begin immediately and continue through implementation.

Purpose

To inform stakeholders that HIPAA will be implemented in October 2003 and what impact HIPAA will have on their business.

Activities

- The EDS-NHIC Web site will be regularly updated with current information. All information sent to providers and disseminated through provider workshops and visits will also appear at this Web site.
- Initial article in the Texas Medicaid Bulletin. An article will appear in the *January/February 2003 Texas Medicaid Bulletin* and provide general information to all providers informing them of the HIPAA implementation date. The article will emphasize key areas such as hardware requirements for TDHconnect, changes in transaction sets for electronic claims submission, the importance of vendors successfully testing, changes in procedure codes, and training/education opportunities. This article will be an introductory article with subsequent bulletins providing more detailed information.
- Development of informational brochure(s) that identify, at a general level, major changes resulting from HIPAA, including references for more detailed information (that is, Web sites regarding privacy provisions). The brochures will be provided in all workshops conducted by NHIC beginning in 2003, distributed during provider visits, and posted on the EDS-NHIC Web site.
- Incorporate HIPAA information into all provider education activities
- Articles in professional association publications. We will work closely with state associations, as well as local/county associations, to develop educational and informative information about HIPAA as it relates to Medicaid claims submission and processing.
- Banner messages will be used to remind providers of activities that are going on in preparation of HIPAA implementation.

- Hold messages in the customer service center will be used to reinforce activities in preparation of HIPAA implementation.
- Special Medicaid and CSHCN Bulletins will be prepared and mailed to providers for receipt at least 30 days before implementation. This will provide necessary information to "supplement" their *2003 Texas Medicaid Provider Procedures Manual.*
- Establish a provider Red Room for quick identification and resolution of provider questions and issues.

Providers

- The HIPAA information will be added to the Web site – initially informing providers of the October 2003 implementation date. This site will be used throughout the year to post up-to-date information about HIPAA.
- HIPAA brochures will be developed and available for use beginning in the first quarter of 2003. This brochure will provide an overview of HIPAA and highlight changes to the Medicaid program as a result of HIPAA.
- Bulletin articles will be published in all upcoming Medicaid and CSHCN bulletins, beginning with the *January/February 2003 Texas Medicaid Bulletin*. These articles will begin with general information with subsequent articles focusing on specific topics.
- A Special Bulletin will be developed and mailed to all providers beginning in August 2003. This bulletin will cover changes that impact providers and include the detailed timeline of implementation activities. This special bulletin is necessary since HIPAA changes will not be included in the *2003 Texas Medicaid Provider Procedures Manual.*

Vendors

- Vendors will receive the same information given to providers
- Information on HIPAA implementation date will be added to the Web site that vendors normally access – texmednet.com.
- Vendor workshops will be held so that vendors are prepared for testing. These workshops will occur in the first quarter of 2003. Invitations and information on the workshops will be provided by at least 30 days before the workshop date(s).

Note: The category of "Vendors" includes those providers that "direct submit" to NHIC using vendor specifications (that is, UB92, X12).

Provider Advisory Council

The Provider Advisory Council is composed of representatives from major professional associations, state agencies, and providers enrolled in the Texas Medicaid Program. This council is used to assist in getting information out to the

provider community as well as providing guidance and direction on the type of information needed and how best to reach the provider community.

Council members who helped prepare for *Compass21* will be contacted to determine their interest in continued participation; "gaps" in participation will be filled with input from HHSC and the professional associations. The Provider Advisory Council will reconvene during the first quarter of 2003.

Vendor Council

The vendor council is composed of billing services/vendors that submit claims electronically to NHIC on behalf of providers. Like the provider advisory council, they assist in getting information out to other vendors, provide feedback on training and assistance needs, and provide guidance on what difficulties may be encountered as specification changes are made for HIPAA.

The *Compass21* participants will be contacted to determine their interest in continued participation; "gaps" in participation will be filled with input from HHSC and the professional associations. The Vendor Council will reconvene during the first quarter of 2003 and meet jointly with the Provider Advisory Council.

Professional Associations

The professional associations (state, county, and local) are key to the success of notifying providers of the changes for HIPAA. They will be included from the "ground up" to discuss communication, training, how to best reach the provider community, and use of their forums (conferences, conventions, training, publications, etc.) to reach their memberships.

Professional associations will be sent copies of all materials sent to providers.

Meetings will be held with key personnel from each association starting at the state level and then moving out to local groups. Whenever possible, personnel from the state association will be asked to participate in meetings at the county and/or local level.

- Each major professional association (TMA, THA, TDA, TOMA, TACHC) is represented on the provider advisory council.
- NHIC will coordinate with professional associations to include HIPAA information in association publications, Web sites, and so forth.
- In addition to state associations, we will work with large local associations to ensure information is disseminated to their membership. Local associations that have been helpful in the past are: Bexar County Medical Society, Harris County Medical Society, and Dallas County Medical Society. Others can be added as necessary.

Medicaid, Managed Care Organizations, and TMAS Contractors

- NHIC will advise MCOs and TMAS contractors regarding information disseminated to the Medicaid providers relative to HIPAA implementation.
- HIPAA will be a standing topic of discussion for the weekly scan call with all MCOs and TMAS contractors.
- Meetings to discuss policy specific topics related to HIPAA (that is, procedure code changes) will be conducted. The coordination and starting date for these meetings has not yet been established.
- A copy of the brochure will be posted on the BBS at the MCO Library.

Education

Although notification is a form of education, the formal education will begin in the second quarter of 2003.

Purpose

The goal of this education effort is for every active Medicaid provider, certified vendor, professional association, state agency, major Medicare carrier, and TMAS contractor including HMOs to attend a workshop or receive information regarding HIPAA implementation prior to implementation.

Process

- NHIC will schedule workshops in 20 to 30 locations statewide for Medicaid, managed care, CSHCN, family planning, and long-term care providers. Where appropriate the agenda will allow for separate sessions for provider-specific information based on the program (that is, long-term care providers would have a separate session regarding procedure codes). These workshops will be conducted in conjunction with the contractually required workshops for physicians, hospitals, CSHCN, and long-term care providers. Workshops will begin in the second quarter of 2003 and will be conducted by the NHIC Provider Relations Training Specialists. All workshops conducted in 2003, leading up to the October 2003 implementation of HIPAA, will contain detailed information for providers regarding HIPPA changes. Invitations will be sent to all stakeholders at least 30 days before workshop date(s) and will also be posted on the EDS-NHIC Web site.
- NHIC will work with professional associations to participate/present at major professional association meetings and conventions. Contact with these associations will begin the first quarter of 2003. Information provided at 2003 conventions will highlight HIPAA implementation.
- Training Specialists will schedule visits/inservices with high volume Medicaid providers that were unable to attend a workshop. This activity will begin when the workshops are completed.

- Articles will be placed in the Texas Medicaid Bulletin and in professional associations' publications..
- The HIPAA Special Bulletin will be distributed to supplement the 2003 Texas Medicaid Provider Procedures Manual and CSHCN Provider Procedures Manual.

Follow Up

Follow-up is that period after implementation. Experience shows once you move into operations, some issues and questions will surface that were not anticipated.

Purpose

To continue to provide assistance to providers, associations, TMAS contractors, and so forth, during the period immediately following implementation.

Process

- Develop Medicaid Bulletin articles that focus on issues and concerns expressed by providers.
- Visit providers having difficulty with implementation to resolve concerns.
- Develop FAQ and post to the Web site.
- Meet with Provider Advisory and Vendor Councils within one month of implementation to assess additional training needs.

Testing

TDHconnect Provider Pilot

Before deployment of the HIPAA compliant version of TDHconnect, a provider pilot test group will be selected for testing of the application. Participants in the pilot will work directly with NHIC's electronic data interchange staff to "test drive" the application and ready it for implementation.

Vendor Testing

We will conduct vendor workshops in three to four locations during the first quarter of 2003 to prepare vendors for testing beginning April 2003.

Note: For the Provider Communication Plan submitted to HHSC refer to NCARTS N10222002PRO001.

Glossary

The following terms and their definitions are used in this document:

Term	Definition
Acute Care System	The claims processing, payment and reporting portion of *Compass21*.
AIS	Automated Inquiry System; Used for eligibility verification, availability of benefits limits, and outstanding prior authorizations.
Ad Hoc Datamart	Database containing claim, client and provider information received from several subsystems designed to meet reporting needs through the use of impromptu queries.
Adjustments	A claim that is submitted for the purpose of correcting a previously paid claim.
ANSI	American National Standards Institute
ASC	Accredited Standards Committee
Atypical Service	A non-medical procedure
BBS	Bulletin Board System
CARC	Claim Adjustment Reason Codes; National standard codes representing claim status and denial reasons on the 835.
CSHCN	Children with Special Health Care Needs; A medical services program designed to identify and medically assist children with certain disabling and/or chronic medical conditions who might otherwise be unable to benefit from present or future educational or employment opportunities.
CSCC	Claim Status Category Codes; National standard codes representing claim status and denial reasons on the 277.
CSC	Claim Status Codes; National standard codes representing claim status and denial reasons on the 277.
CSI	Claim Status Inquiry; Transaction used to convey claim payment and status to a provider.
Clearinghouse	The entity through which transactions will pass between the provider and NHIC where X12N transactions will be mapped to the state-defined formats used by the TMMIS.
Covered Entity	Health plan, clearinghouse, or provider that performs business functions identified by HIPAA as required to follow the standards.
Covered Transaction	One that conveys information that falls under the standards identified by HIPAA.
Crossovers	Claims for Medicare deductible and coinsurance charges on an already paid Medicare claim that may electronically “cross over” from Medicare to Medicaid for payment.

Term	Definition
DHS	Texas Department of Human Services; Administers the Long Term Care program.
DSMO	Designated Standards Maintenance Organization
EBX	Clearinghouse currently used by the TMMIS.
EDI	Electronic Data Interchange
EDIFACT	Format used to perform eligibility inquiries in the Acute Care system.
Encounters	Paid claim information sent to the Acute Care system via interface from Managed Care Organizations.
EOB	Explanation of Benefit; Utilized by the TMMIS to reflect claim status and denial/rejection reasons. Local codes.
EOP	Explanation of Pended Status; Utilized by the TMMIS to reflect claim status and suspense reasons. Local codes.
ER&S	Electronic Remittance and Status; Report used in the TMMIS to convey claim status and denial reasons, as well as payment information.
Front-End Edit	An edit that is performed prior to the claim being adjudicated by the TMMIS.
HCPCS	Health Care Financing Administration Common Procedural Coding System codes; National standard procedure codes accepted on all three HIPAA compliant claim formats.
Help Desk	NHIC EDI Help Desk team
HHSC	Texas Health and Human Services Commission
HHSC HIPAA Review Board	Committee comprised of HHSC staff members that approved Definition and Analysis documents prepared by the Acute Care team.
HIPAA	Health Insurance Portability and Accountability Act of 1996; Established standards for electronic Transactions and Code Sets.
ICD-9	International Classification of Diseases Diagnosis codes; National standard diagnosis codes accepted on the Institutional claim format.
ICN	Internal Control Number; Unique number assigned to each claim accepted into the TMMIS for processing; Used for tracking purposes.
ImmTrac	Immunization Tracking System
Implementation Guide	A resource outlining the HIPAA standards for each transaction in an effort to facilitate a smooth and consistent transition.
LTC	Long Term Care System; Claims processing system for DHS/MHMR Long Term Care.
MESAV	Medicaid Eligibility and Service Authorization Verification; Used to provide Long term care providers with information regarding client eligibility.
MHMR	Texas Department of Mental Health and Mental Retardation

Term	Definition
MSIS	Medicaid Statistical Information System
NCPDP	National Council for Prescription Drug Programs;
NDC	National Drug Code
NHIC	National Heritage Insurance Company; Contracted by HHSC/DHS for the Claims Administrator and the HIPAA Assessment contracts.
NHIC HIPAA Review Board	Committee comprised of NHIC staff members that reviewed and approved Definition and Analysis documents prepared by the Acute Care team. Implemented to ensure accuracy and completeness of all documents.
PA	Prior Authorization; The process of obtaining coverage approval for a medical service.
PCN	Patient Account Number; Identifier used with in the Acute Care system for each client.
RA	Remittance Advice; HIPAA compliant 835; Used to convey claims status, denial reasons and provider payment information.
RARC	Remittance Advice Remark Codes; National standard codes representing claim status and denial reasons on the 835.
SNIP	Strategic National Implementation Process
STAT	Statistical reporting conducted by the Acute Care system.
SURS	Surveillance and Utilization Review System;
TARS	Texas Automated Recovery System
TDHconnect	Software available to providers for claims submission, eligibility inquiry, claim status inquiry and ER&S review.
TDHvision	Web-based application utilized for queries against the ad hoc databases.
Texas Medicaid Companion Guide	A resource that will illustrate the TMMIS specific requirements for each transaction. For example, if a data element should be populated in a specific way for the TMMIS, this will be indicated in this guide.
TFE	Tandem Front End; Format send to and from the TMMIS for all transactions.
THSteps	Texas Health Steps; the state version of the national EPSDT program.
TMMIS	Texas Medicaid Management Information System; Encompasses the Acute Care System and the Long Term Care System.
TPI	Texas Provider Identifier
TPL	Third Party Liability
TPR	Third Party Resource
Trading Partners	Any entity with whom the TMMIS exchanges electronic data.
VAN	Value Added Network

Term	Definition
Vendor	Provider, or entity working on behalf of a provider, that submits electronic transactions to the TMMIS for processing.
Vision 21	Ad Hoc reporting component of the TMMIS; contains claim information for both the Acute Care and Long Term Care system.
WEDI	Workgroup for Electronic Data Interchange
X12N	Standardized HIPAA compliant transaction format.
Z01	Eligibility accept/reject response file for from the TMMIS to providers via EBX.
Z03	Response file for ER&S from the TMMIS to providers via EBX.
Z05	Response file for ER&S from the TMMIS to providers via EBX.
Z06	Claim accept/reject response file from the TMMIS to providers via EBX.
Z07	Transactions acknowledgment file from EBX to providers; may also be a 997.
Z13	Claim Status Inquiry accept/reject response file from the TMMIS to providers via EBX for Claims Request type CSIs.
Z26	Response file for claim status inquiry from the TMMIS to providers via EBX for all CSI requests other than Claims Request.
ZZZ	Response file for transactions from EBX to providers; indicates problematic file.

Appendix

The following appendices may be found on the CD-ROM:

Appendix A – Issues List

Appendix B – Code Set Mappings

Appendix C – Analysis Documents

Appendix D – Approach Document

Appendix E – Local Codes Remediation Recommendations

Appendix F – List of Interface Files

Appendix G – Table of impacted Interface Files